

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12660

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	c. LENGTH OF STAY IN 1b 3 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Wheaton, S.S.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11712 Viers Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clay Todd Ackerman		4. DATE OF DEATH Month Nov. Day 19 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/59
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robt. E. Ackerman		14. MOTHER'S MAIDEN NAME Ora Lee Culver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Item 2	
17. INFORMANT Robt. E. Ackerman		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Upper Respiratory Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 475X (c) 475X			INTERVAL BETWEEN ONSET AND DEATH Found dead in bed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 11/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/21/59	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-443881-104

12701

CERTIFICATE OF DEATH

Reg. Dist. No.

12661

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pikesville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>		d. STREET ADDRESS <u>14-Drexel Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>SUSAN</u> First <u>Catherine</u> Middle <u>King</u> Last <u>Albert</u>		4. DATE OF DEATH <u>November 29</u> 19 <u>59</u> Month <u>November</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Junction Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Col. George W. King</u>		14. MOTHER'S MAIDEN NAME <u>Susan Catherine D'Adelot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Bertha D. K. Freeman</u> Address <u>5320 4th St. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO (c) <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1959</u> to <u>November 29, 1959</u> that I last saw the deceased alive on <u>November 29, 1959</u> and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Loftus</u> M.D.		ADDRESS (Street, city or town, state) <u>1673 Park Road N.W. Washington 10, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>James M. Loftus</u>		DATE SIGNED <u>Nov. 29/1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 Ga An Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12701



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12662

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u> c. LENGTH OF STAY IN 1b <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6335 Ridge Dr</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u> d. STREET ADDRESS <u>6335 Ridge Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frederick William Arnold</u> First Middle Last		4. DATE OF DEATH <u>Nov 8 1959</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-88</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Printing</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Gustave Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Ernestine Zinner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ely Arnold (wife)</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema 5 yrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-8-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> Address <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PREVIOUS ILLNESS _____		PHYSICIAN'S NAME _____	
TIME OF DEATH _____		SIGNATURE OF MEDICAL EXAMINER _____	
DATE OF DEATH _____		OFFICIAL SEAL _____	

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This certificate is to be filled out by the medical examiner who has examined the body of the deceased. It is to be filed in the office of the Bureau of Vital Statistics, Department of Health, State of Illinois, and a copy is to be sent to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12663

12703

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 58 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83 X - 3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 2810 Elmwood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gay Ellen ATHEY		4. DATE OF DEATH Month Day Year November 9 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-47
9. AGE (In years last birthday) 11 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward ATHEY	
14. MOTHER'S MAIDEN NAME Eileen SHANDOLPZER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Edward Athey	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 227X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive pulmonary involvement DUE TO (c) Mesothelioma INTERVAL BETWEEN ONSET AND DEATH 3 wks 1 yr.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhage into intestine			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 September, 1959 , to 9 November, 1959 , that I last saw the deceased alive on 9 November, 1959 , and that death occurred at 3:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-9-59			
ACTUAL SIGNATURE G.B. Avery		M.D. U.S. Naval Hospital, Bethesda Md. 11-9-59	
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE Demaine 520 South Washington St. Alexandria Va.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	24b. REGISTRAR'S SIGNATURE C. L. & H. H. H.

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Virginia

Washington

2200 Howard Drive

November

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U.S.

District of Columbia

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12664

12704

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1525 GREYSTONE ST.				d. STREET ADDRESS 1525 GREYSTONE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA BACHARACH				4. DATE OF DEATH Month Day Year NOVEMBER 27 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 17, 1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME LOESER ADLER				14. MOTHER'S MAIDEN NAME MATHILDA --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT JOSEPH B. DRATCH		Address 5525 GREYSTONE ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Breast DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4/26/57 11/27/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-26 , 19 57 , to 11/27 , 19 59 , that I last saw the deceased alive on 11-25 , 19 59 , and that death occurred at 3:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DAVID H KUSHNER M.D. 1302-1821 24							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) DAVID H KUSHNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 29, 1959		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS				ADDRESS 3501-14 ST. NW		24a. REC'D BY REGISTRAR DEC 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>	
<p>4. DATE OF DEATH [Handwritten: Jan 15, 1918]</p>		<p>5. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>6. PLACE OF DEATH [Handwritten: Home]</p>	
<p>7. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>8. DISEASE OR INJURY [Handwritten: Myocardial Infarction]</p>		<p>9. MODE OF DEATH [Handwritten: Natural]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]</p>		<p>11. SIGNATURE OF WITNESSES [Handwritten: J. H. Smith, J. D. Jones]</p>		<p>12. SIGNATURE OF DECEASED [Handwritten: John Doe]</p>	
<p>13. SIGNATURE OF REGISTRAR [Handwritten: J. H. Smith]</p>		<p>14. SIGNATURE OF CLERK [Handwritten: J. D. Jones]</p>		<p>15. SIGNATURE OF DECEASED [Handwritten: John Doe]</p>	

1 12705 090 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G252 11-25-59 et

CERTIFICATE OF DEATH

12665

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 4 yrs 1 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				e. STREET ADDRESS 3609 Buena Vista Avenue			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Baer				4. DATE OF DEATH Month November Day 18 Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Young				14. MOTHER'S MAIDEN NAME Mary E. Albaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of sigmoid & metastasis 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8-21-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 56 , to Nov 18 , 19 57 , that I last saw the deceased alive on Nov 11 , 19 59 , and that death occurred at 9:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sarah E. Glover M.D. 10128 Cedar Lane, Kensington, Md. PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-59		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg, Md.				24a. REC'D BY REGISTRAR NOV 20 59		24b. REGISTRAR'S SIGNATURE Carlton S. Knead	

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
OCCASION OF DEATH _____		CAUSE OF DEATH _____	
MEDICAL HISTORY _____		HISTORY OF PRESENT ILLNESS _____	
PHYSICIAN'S SIGNATURE _____		SIGNATURE OF DECEASED _____	
PHYSICIAN'S NAME _____		NAME OF DECEASED _____	
ADDRESS _____		ADDRESS _____	
CITY _____		CITY _____	
STATE _____		STATE _____	
COUNTY _____		COUNTY _____	
ZIP CODE _____		ZIP CODE _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF DECEASED _____	
REGISTRAR'S NAME _____		NAME OF DECEASED _____	
ADDRESS _____		ADDRESS _____	
CITY _____		CITY _____	
STATE _____		STATE _____	
COUNTY _____		COUNTY _____	
ZIP CODE _____		ZIP CODE _____	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1971, CH. 29, § 2-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1971, CH. 29, § 2-102.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12666

Reg. Dist. No.

12706

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9825 Singleton St</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9825 Singleton St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Regina Maria Baer</u> First Middle Last				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1959</u>															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-1874</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>				12. CITIZEN OF WHAT COUNTRY? <u>NATURALIZED</u> <u>U.S.A.</u>									
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Jan Clifford - Item #2-great grand child</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED											
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-18-59</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12707

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 46 Salamaua Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Theresa Middle Dianne Last BARBER		4. DATE OF DEATH		Month November Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-56		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Darwin L. BARBER				14. MOTHER'S MAIDEN NAME Betty A MC KEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT (Father) Darwin E BARBER		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO 180x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive tumor involvement of chest and abdomen DUE TO Wilms tumor (c) 180x						INTERVAL BETWEEN ONSET AND DEATH immediate 2 wks. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 October , 19 59 , to 6 November , 19 59 , that I last saw the deceased alive on 6 November , 19 59 , and that death occurred at 6:15A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE LB Avery				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-6-59			
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Beatrice Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

785

(1927) 1927

33-4796

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D. J. C.

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[illegible]

3.0

DATE: 1-1-1964

C11

$$f(x) = \frac{1}{x^2} = x^{-2} \Rightarrow f'(x) = -2x^{-3} = -\frac{2}{x^3}$$
 2.22 ± 0.54

92-8-21

1990年12月29日

1950-1951 年 10 月 20 日。

92-01-11

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13, 14 Film G252 11-25-59 et

Reg. Dist. No.

12668

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 4813 Wellington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle E. W. Last Bargagni		4. DATE OF DEATH Month 11 Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 9 Days 15	IF UNDER 24 HRS. Hours 16 Min. 19 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Macaboy Macaboy		14. MOTHER'S MAIDEN NAME Unknown Louise D. Tadaldi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mary Bargagni		Address 4813 Wellington Dr. (Daughter in law)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschert M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12669

12709

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Theresa</i> Middle <i>C.</i> Last <i>Barrett</i>		4. DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 22 1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED U.S. GOVT.</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Patrick Welsh</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Dunn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>DR. Barrett Son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 congestive failure</i> DUE TO <i>ASCD</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>ASCD</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes - diabetic gangrene lips</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1957</i> to <i>Nov 11 1959</i> , that I last saw the deceased alive on <i>Nov 11 1959</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Horace W. Bernton</i> M.D.		ADDRESS (Street, city or town, state) <i>10511 SUMMIT AVE. KENSINGTON, MD.</i> DATE SIGNED <i>11/11/59</i>	
PHYSICIAN'S NAME (Type) <i>HORACE W. BERTON</i>		A1	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-14-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT OLIVET CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i> ADDRESS <i>3821-14th St. NW. Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>NOV 13 59</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>Wilbur & Kinn</i>			

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12710

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Spencer c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer d. STREET ADDRESS 515 5th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jackson Lee BARRINGER				4. DATE OF DEATH Month Day Year November 28 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-34	
9. AGE (In years last birthday) yrs. 25		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Benjamin A. BARRINGER				14. MOTHER'S MAIDEN NAME Lorena S. ARENDT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1958 to 1959				16. SOCIAL SECURITY NO. 241-42-992			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intra-cranial pressure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain tumor (Glioblastoma) DUE TO (c) 1 mo				INTERVAL BETWEEN ONSET AND DEATH 1 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 November 1959 to 28 November 1959 that I last saw the deceased alive on 28 November 1959 , and that death occurred at 1150A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 11-29-59							
ACTUAL SIGNATURE A. T. THORP Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) A. T. THORP Jr., LT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY National		22d. LOCATION (City, town, or county) (State) Salisbury, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St. NW, Wash., D.C.		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

MEDICAL CERTIFICATION

1. *Level 1: Level 1*

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12671

CERTIFICATE OF DEATH

Reg. Dist. No.

12696

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b X 3 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 714 Beall Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle BAUGH Last		4. DATE OF DEATH Month Nov. 13, Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1870
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 5 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lime Stone Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Baugh		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 317-05-0555	
17. INFORMANT Son		18. ADDRESS 203 Croydon Ave. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 Pyloric obstruction DUE TO Gastric ulceration Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chl. Emphysema + ASH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/26/1957 , to 11/13/1957 , that I last saw the deceased alive on 11/13/1957 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 11/14/57	
PHYSICIAN'S NAME (Type) STEPHEN N. JONES		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 11/18/59	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian Church Cem. Ellettsville, Indiana		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

12711

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHSDA				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS SHADYSIDE 02X-2			
3. NAME OF DECEASED (Type or print) First Middle Last ELMER R BAYNE				4. DATE OF DEATH Month Day Year Nov 10 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/4/04	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yacht Club Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Clinton, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Hugh Richard Bayne				14. MOTHER'S MAIDEN NAME Mary E Lovelless			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Mrs. Audrey Bayne Shady Side, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulonephritis DUE TO (c) Chronic Glomerulonephritis						INTERVAL BETWEEN ONSET AND DEATH 2 days, 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-18 , 19 59 , to 11-10 , 19 59 , that I last saw the deceased alive on 11-10 , 19 59 and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Bailey M.D.				ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED Nov 11-10-59			
PHYSICIAN'S NAME (Type) JOSEPH A. BAILEY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV-13th		22c. NAME OF CEMETERY OR CREMATORY GEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS 1661 Good Hope Rd. Wash DC				24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE William L. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1871

DECEASED
DISEASE
PLACE
AGE
SEX
OCCUPATION
CAUSE
DATE
PLACE
BY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12673

12712

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3517 Shepherd Street</u>				d. STREET ADDRESS <u>3517 Shepherd Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>YEATMAN</u> Last <u>BEACH</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1864</u>		9. AGE (In years last birthday) <u>95</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>			
13. FATHER'S NAME <u>Robert Henry Yeatman</u>				14. MOTHER'S MAIDEN NAME <u>MaryOlivia Simpson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elva Gifford-Niece-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/30/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Charles L. Kenna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. SIGNATURE OF MEDICAL EXAMINER [REDACTED]		11. SIGNATURE OF DECEASED [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]	
16. SIGNATURE OF WITNESS [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]		21. SIGNATURE OF WITNESS [REDACTED]	
22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF WITNESS [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]	
28. SIGNATURE OF WITNESS [REDACTED]		29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF WITNESS [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]		33. SIGNATURE OF WITNESS [REDACTED]	
34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF WITNESS [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF WITNESS [REDACTED]	
40. SIGNATURE OF WITNESS [REDACTED]		41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF WITNESS [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]		45. SIGNATURE OF WITNESS [REDACTED]	
46. SIGNATURE OF WITNESS [REDACTED]		47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF WITNESS [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]		51. SIGNATURE OF WITNESS [REDACTED]	
52. SIGNATURE OF WITNESS [REDACTED]		53. SIGNATURE OF WITNESS [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]	
55. SIGNATURE OF WITNESS [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]		57. SIGNATURE OF WITNESS [REDACTED]	
58. SIGNATURE OF WITNESS [REDACTED]		59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF WITNESS [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF WITNESS [REDACTED]	
64. SIGNATURE OF WITNESS [REDACTED]		65. SIGNATURE OF WITNESS [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]		69. SIGNATURE OF WITNESS [REDACTED]	
70. SIGNATURE OF WITNESS [REDACTED]		71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF WITNESS [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF WITNESS [REDACTED]	
76. SIGNATURE OF WITNESS [REDACTED]		77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]	
79. SIGNATURE OF WITNESS [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]		81. SIGNATURE OF WITNESS [REDACTED]	
82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF WITNESS [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF WITNESS [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF WITNESS [REDACTED]	
88. SIGNATURE OF WITNESS [REDACTED]		89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF WITNESS [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]		93. SIGNATURE OF WITNESS [REDACTED]	
94. SIGNATURE OF WITNESS [REDACTED]		95. SIGNATURE OF WITNESS [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF WITNESS [REDACTED]	
100. SIGNATURE OF WITNESS [REDACTED]		101. SIGNATURE OF WITNESS [REDACTED]		102. SIGNATURE OF WITNESS [REDACTED]	



12345

12345

Robert A. [REDACTED] [REDACTED] [REDACTED]

CERTIFICATE OF DEATH

Reg. Dist. No.

12713

12674

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND c. LENGTH OF STAY IN lb 1 year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C. d. STREET ADDRESS 4535 - 30th ST., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle C. Last BEACH				4. DATE OF DEATH Month NOVEMBER Day 14 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 17, 1868	
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) MICHIGAN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALVIN BEACH				14. MOTHER'S MAIDEN NAME ARVILLA BULLOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Miss Sandra Beach, 1240 No. Quinn St., Arlington, Va.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized arteriosclerosis (b) Unknown (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death Sudden death							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 29 , 19 58 , to Nov 14 , 19 59 , that I lost saw the deceased alive on Oct 20 , 19 59 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron H. Traum				ADDRESS (Street, city or town, state) 8237 Georgia Ave, Silver Spring Md			
DATE SIGNED Nov 16/59							
PHYSICIAN'S NAME (Type) AARON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska				ADDRESS Silver Spring, Md.			
24a. REC'D BY REGISTRAR NOV 18 '59				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12712

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

DATE

TIME

PLACE

BY

DATE

TIME

PLACE

BY

DATE

TIME

PLACE

BY

12714

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, BETHESDA MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle Roy Last BENSON				4. DATE OF DEATH Month November Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-56	9. AGE (In years lost birthday) 3 yrs.	IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME FREDERICK R. BENSON				14. MOTHER'S MAIDEN NAME ARLENE FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Total Body Irradiation DUE TO (c) Acute Lymphatic Leukemia							INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 hrs. 9 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 November, 1959 to 13 November, 1959 , that I last saw the deceased alive on 13 November, 1959 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G.B. Avery				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-14-59			
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphery ADDRESS 7557 Wisconsin Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR NOV 19 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

051

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VS A15 (4)
15M 9/58

1947
215

U.S. Naval Hospital, Bethesda, Md.
November 13, 1947
Mr. J. Edgar Hoover
Washington, D.C.
Dear Mr. Hoover:
I am writing you to inform you that the following information was received from the U.S. Naval Hospital, Bethesda, Md., on November 13, 1947:

1. Mr. J. Edgar Hoover
2. Mr. J. Edgar Hoover
3. Mr. J. Edgar Hoover
4. Mr. J. Edgar Hoover
5. Mr. J. Edgar Hoover
6. Mr. J. Edgar Hoover
7. Mr. J. Edgar Hoover
8. Mr. J. Edgar Hoover
9. Mr. J. Edgar Hoover
10. Mr. J. Edgar Hoover

U.S. Naval Hospital, Bethesda, Md.
November 13, 1947
Mr. J. Edgar Hoover
Washington, D.C.
Dear Mr. Hoover:
I am writing you to inform you that the following information was received from the U.S. Naval Hospital, Bethesda, Md., on November 13, 1947:

12715

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor San. 9200 Wisconsin Ave.				d. STREET ADDRESS 5420 Conn. Avenue N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lucy J. BERTHRONG		First Middle Last		4. DATE OF DEATH Nov. 10 1959		Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1863		9. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Jones				14. MOTHER'S MAIDEN NAME Rachael Jarboe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Mrs. W. B. Hill-3933 Legation St. N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1948 to Nov 10, 1959 that I last saw the deceased alive on Oct 26, 1959 , and that death occurred at 3 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas Sappington M.D.				ADDRESS (Street, city or town, state) 1025 CONN AVE, N.W. WASHINGTON, D.C.			
PHYSICIAN'S NAME (Type) THOMAS S SAPPINGTON				DATE NOV 12 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company Washington, DC				24a. REC'D BY REGISTRAR NOV 12 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12715

CENTRAL OF DEATH

Montgomery

Bedford

Washington, D. C.

3200 Wisconsin Ave. N.W. 3200 Conn. Avenue N.W.

Lucy

White

White

Married

Married

John Jones

Robert Jones

Name

Mrs. W. F. Hill-1003

John & Mary Thompson

John & Mary Thompson

Washington, D. C.

Rock Creek Cemetery

11/15/50

Final

The D. N. Jones Company Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12716 Item 21, Film G-253 12/14/59.cac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>4518 Roxbury Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4518 Roxbury Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Douglas Lee Bizzell</u>		4. DATE OF DEATH Month Day Year <u>11-10-1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-43</u>
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Bizzell</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Lohr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Oscar Bizzell (father)</u>		Address <u>Ilum 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by hanging</u> 936.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self in bath room at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bethesda Montg Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-10-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur, transit</u>	22b. DATE THEREOF <u>11/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Newton Grove, N. Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Nov 12 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCASION OF DEATH <i>Heart Disease</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12674

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>		d. STREET ADDRESS <u>8605 Mayfair Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>HERMAN</u> Last <u>BONK</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 19, 1907</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERN</u>		11. BIRTHPLACE (State or foreign country) <u>Min. MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>JOHN BONK</u>				14. MOTHER'S MAIDEN NAME <u>MARY BLESI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W. II</u>		17. INFORMANT <u>Alice Bonk -</u>		Address <u>Stum 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic Aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>823X</u> <u>Driven car which failed to make curve & struck tree</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12:30</u> p.m. <u>11-26</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Colleville Monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Unothy Haulon</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Family		18. Signature of Friends	
19. Signature of Neighbors		20. Signature of Community		21. Signature of State	
22. Signature of Nation		23. Signature of World		24. Signature of Universe	
25. Signature of God		26. Signature of Heaven		27. Signature of Hell	
28. Signature of Purgatory		29. Signature of Limbo		30. Signature of Limbo	
31. Signature of Limbo		32. Signature of Limbo		33. Signature of Limbo	
34. Signature of Limbo		35. Signature of Limbo		36. Signature of Limbo	
37. Signature of Limbo		38. Signature of Limbo		39. Signature of Limbo	
40. Signature of Limbo		41. Signature of Limbo		42. Signature of Limbo	
43. Signature of Limbo		44. Signature of Limbo		45. Signature of Limbo	
46. Signature of Limbo		47. Signature of Limbo		48. Signature of Limbo	
49. Signature of Limbo		50. Signature of Limbo		51. Signature of Limbo	
52. Signature of Limbo		53. Signature of Limbo		54. Signature of Limbo	
55. Signature of Limbo		56. Signature of Limbo		57. Signature of Limbo	
58. Signature of Limbo		59. Signature of Limbo		60. Signature of Limbo	
61. Signature of Limbo		62. Signature of Limbo		63. Signature of Limbo	
64. Signature of Limbo		65. Signature of Limbo		66. Signature of Limbo	
67. Signature of Limbo		68. Signature of Limbo		69. Signature of Limbo	
70. Signature of Limbo		71. Signature of Limbo		72. Signature of Limbo	
73. Signature of Limbo		74. Signature of Limbo		75. Signature of Limbo	
76. Signature of Limbo		77. Signature of Limbo		78. Signature of Limbo	
79. Signature of Limbo		80. Signature of Limbo		81. Signature of Limbo	
82. Signature of Limbo		83. Signature of Limbo		84. Signature of Limbo	
85. Signature of Limbo		86. Signature of Limbo		87. Signature of Limbo	
88. Signature of Limbo		89. Signature of Limbo		90. Signature of Limbo	
91. Signature of Limbo		92. Signature of Limbo		93. Signature of Limbo	
94. Signature of Limbo		95. Signature of Limbo		96. Signature of Limbo	
97. Signature of Limbo		98. Signature of Limbo		99. Signature of Limbo	
100. Signature of Limbo		101. Signature of Limbo		102. Signature of Limbo	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12679

12717

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25 0250-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 5901 Belle Grove Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clyde Middle Boone Last Boone		4. DATE OF DEATH Month 11 Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/19
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Road construction	
11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wiley Boone		14. MOTHER'S MAIDEN NAME Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Wing W. W.	
17. INFORMANT Rosa Lee Boone - Wife - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed while working on road construction		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Brumhart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Fayetteville, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart		ADDRESS 30 H Street, N.E.	
24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Charles S. Howard	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12680

Reg. Dist. No.

12718

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 15 MIN.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				d. STREET ADDRESS BONIFANT ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle PEARL Last BOWIE				4. DATE OF DEATH Month NOVEMBER Day 13 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/23/98 95	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 13		IF UNDER 24 HRS. Hours 13 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) REXTON-NEW BRUNSWICK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J. P. KINREAD				14. MOTHER'S MAIDEN NAME Pearl Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE SUB-DURAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CEREBRO-VASCULAR ACCIDENT DUE TO (c) 2 HRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) F. J. BROSCART, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zucka				24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Christina S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF MONTGOMERY CITY OF BALTIMORE		DECEASED NAME: [REDACTED]	
PLACE OF BIRTH: [REDACTED]		DATE OF BIRTH: [REDACTED]	
PLACE OF DEATH: [REDACTED]		DATE OF DEATH: [REDACTED]	
OCCASION OF DEATH: [REDACTED]		CAUSE OF DEATH: [REDACTED]	
MANNER OF DEATH: [REDACTED]		MEDICAL HISTORY: [REDACTED]	
PRESENT ILLNESS: [REDACTED]		TREATMENT: [REDACTED]	
PHYSICIAN: [REDACTED]		SECOND PHYSICIAN: [REDACTED]	
BURIAL PLACE: [REDACTED]		DATE OF BURIAL: [REDACTED]	
SIGNATURE OF EXAMINER: [REDACTED]		SIGNATURE OF PHYSICIAN: [REDACTED]	
OFFICIAL SEAL: [REDACTED]		OFFICIAL SEAL: [REDACTED]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY OF MONTGOMERY, BALTIMORE, MARYLAND.

12682 Reg. Dist. No. 12720 16. 212720 074 1 2074284XVO VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 15 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. STREET ADDRESS ROCKVILLE C-15	
3. NAME OF DECEASED (Type or print) BABY GIRL CARTER		4. DATE OF DEATH NOVEMBER 15 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 15 1959
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR — Months — Days 14 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George FRANKLIN CARTER		14. MOTHER'S MAIDEN NAME Dorothy RILEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT —		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/15 , 19 59 , to 11/15 , 19 59 , that I last saw the deceased alive on 11/15 , 19 59 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) — DATE SIGNED —			
ACTUAL SIGNATURE John W. Pearlman M.D.			
PHYSICIAN'S NAME (Type) —			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF Nov. 18-59	22c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL	22d. LOCATION (City, town, or county) (State) Old Georgetown Rd. Bethesda Md.
23. FUNERAL DIRECTOR'S SIGNATURE SUBURBAN HOSPITAL		24a. REC'D BY REGISTRAR NOV 23 '59	
ADDRESS 8600 Old Georgetown Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Krasa	

12721

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4614 Harling Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Madge Middle P. Last Carter		4. DATE OF DEATH Month 11 Day 4 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/20/74
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months 7 Days 14	
11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME K. J. H. Perry		14. MOTHER'S MAIDEN NAME Gilliland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daughter Madge C. Goolsby		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42a1 Coronary thrombosis DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic gangrene, Rt. foot.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 56 Harl 4 59		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Nov 4 1959 to Nov 4 1959 , that I last saw the deceased alive on Nov 4 1959 , and that death occurred at 1238 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray, Jr.		ADDRESS (Street, city or town, state) 4422 Eastwood Hwy, Bethesda 14, Md.	
DATE SIGNED Nov 4, 1959			
PHYSICIAN'S NAME (Type) George A. Gray, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/7/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1971

County

State

City

Address

Occupation

Place of Birth

Place of Death

Age

Sex

Color

Height

Weight

Build

Marital Status

Education

Religion

Signature of Registrar

Signature of Physician
 Date of Death
 Place of Death
 Cause of Death
 Manner of Death
 Signature of Medical Examiner
 Date of Autopsy
 Place of Autopsy
 Cause of Autopsy
 Manner of Autopsy
 Signature of Coroner
 Date of Inquest
 Place of Inquest
 Cause of Inquest
 Manner of Inquest
 Signature of Jury
 Date of Verdict
 Place of Verdict
 Cause of Verdict
 Manner of Verdict
 Signature of Judge
 Date of Judgment
 Place of Judgment
 Cause of Judgment
 Manner of Judgment

12722

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MONTGOMERY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 57 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 56111 Durbin Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Steven Middle "V" Last CARTER				4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-15	
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Utah	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph T. CARTER				14. MOTHER'S MAIDEN NAME Effie STEVENS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 481 12 1057			
INFORMANT (Wife) Lucille K. Carter Same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoscaroma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 September , 19 59 , to 4 November , 19 59 , that I last saw the deceased alive on 4 November , 19 59 , and that death occurred at 2:07 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 11-4-59			
ACTUAL SIGNATURE G. Walker Capt MC USA				DATE SIGNED U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) G. WALKER CAPT MC USA				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-59		22c. NAME OF CEMETERY OR CREMATORY Leon		22d. LOCATION (City, town, or county) (State) Leon Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey				ADDRESS 8434 Georgia Ave. Silver Spring Md.		24a. REC'D BY REGISTRAR NOV 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12723

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12hrs. 45 min. X Wheaton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Chupek		4. DATE OF DEATH Month 11 Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/59
9. AGE (In years last birthday) 12		10. IF UNDER 1 YEAR Months 12 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Vincent Chupek		14. MOTHER'S MAIDEN NAME Betty Mary Gordosik	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Michael V. Chupek - above (Father)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Improperly functioning respiratory center (cranial) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Prematurity DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 13 hrs. 13 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 18 Nov. 1959 to 19 Nov. 1959 that I last saw the deceased alive on 19 Nov. 1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Marshall Cuvillier, Jr.		ADDRESS (Street, city or town, state) 1407 Woodside Pkwy, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) L. MARSHALL CUVILLIER, JR.		DATE SIGNED 11/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/20/59	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. POMPHELY INC. Raymond A. Giska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074 314 X 43

CERTIFICATE OF DEATH

1272

21

Montgomery

Fort Verde

June 15, 1918

Superior

John J. ...

Male

White

Single

Married

Age 35

James

White

Male

Married

Female

Michael Vincent

Very early death

Michael V. ...

Interment in ...

Interment in ...

9

8

19

12724

CERTIFICATE OF DEATH

Reg. Dist. No.

12686

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle F. Last Clark		4. DATE OF DEATH Month 11 Day 11 Year 19 59	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/94
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL CLARK		14. MOTHER'S MAIDEN NAME Cecelia GREENAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Coast Guard		16. SOCIAL SECURITY NO. Cecelia L Clark	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute Congestive Heart Failure (c) Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 hrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/2, 1955 to 11/11, 1959 that I last saw the deceased alive on 11/11, 1959 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 11/11/59			
ACTUAL SIGNATURE Stephen N. Jones M.D.		PHYSICIAN'S NAME (Type) Stephen N. Jones Rockville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-1959	
22c. NAME OF CEMETERY OR CREMATORY Washington Hall		22d. LOCATION (City, town, or county) (State) Switzland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE S. G. Mattingly		24a. REC'D BY REGISTRAR 131-11th St. SE	
24b. REGISTRAR'S SIGNATURE DATE NOV 13 '59			

Page 4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

12332

Residence

Age

Sex

1208 1/2 Ave

Occupation

Black

Married

Albany

White

He died

at his residence

on

12/12/1912

Attorney at Law

Rockville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12687	
Item 20 Film 253 12-8-59 ams											
12725											
CERTIFICATE OF DEATH										Reg. Dist. No. 215	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Box 349 Woodyard Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Clarence Middle Herbert Last COLE					4. DATE OF DEATH Month November Day 12 Year 1959						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-90		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 16 Hours 8 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Carmen COLE					14. MOTHER'S MAIDEN NAME Sadie LEWIS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I & II		INFORMANT (Wife) Elsie Cole			Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intracerebral hematoma 900.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) cerebral contusion and laceration DUE TO (c) 2+ weeks 2+ weeks										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reportedly fell down six stairs and received a head injury							
20c. TIME OF INJURY Month, Day, Year 6:30 Hour 10-26-59 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) Unknown (County) (State)			
21. I certify that I attended the deceased from 3 November , 19 59 , to 12 November , 19 59 , that I last saw the deceased alive on 12 November , 19 59 , and that death occurred at 9:30A M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Matthew William Wood M.D.						ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-12-59					
PHYSICIAN'S NAME (Type) M.W. WOOD LCDR MC USN						U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-17-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Gawlers and Sons Inc. ADDRESS 1756 Penn. Ave. N.W. Washington, D.C.						24a. REC'D BY REGISTRAR NOV 19 1959		24b. REGISTRAR'S SIGNATURE Clifton S. Thomas			

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12723

12723 (Rev.)

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

0012

November 12

7-24-30

White

U.S. Government

U.S. Navy

White

White

White

(White) White

White

12 November

12 November

12 November

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

11-11-30

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

12675

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elinor</i> Middle <i>Maude</i> Last <i>Cope</i>		4. DATE OF DEATH Month <i>11</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/31/84</i>
9. AGE (In years lost birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	11. IF UNDER 24 HRS. Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (State or foreign country) <i>Canada</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Amos Morrell</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Caldwell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Washington Sanitarium + Hospital</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Purulent Pleuritis</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Carcinoma</i> DUE TO (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 8</i> , 1957, to <i>Nov 8</i> , 1959, that I last saw the deceased alive on <i>Nov 8</i> , 1959, and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave, Tak. Park</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD</i>		DATE SIGNED <i>11/9/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 12-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR <i>DATE</i>	
24b. REGISTRAR'S SIGNATURE <i>ELLSWORTH ARMACOST 4600 Liberty Hghts.</i>		24c. REGISTRAR'S SIGNATURE <i>NOV 10 '59</i>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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Blank certificate form with horizontal lines for text entry.

TO HOSPITAL CEMETERY: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12726

CERTIFICATE OF DEATH

12689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 days, 7 hrs. 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>620 Ritchie Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>D.</u> Last <u>Copelin</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Copelin</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Dallas Copelin</u>		Address <u>808 Ingraham St. NW. Washington, D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Papillary Carcinoma of Urinary Bladder</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11</u> , 19 <u>59</u> , to <u>11/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>59</u> , and that death occurred at <u>3:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Timothy J. Tehan M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8218 Wisconsin Ave. Bethesda, Md.</u> <u>11/26/59</u>	
PHYSICIAN'S NAME (Type) <u>Timothy J. Tehan, M.D.</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BROOKING GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>LAYTONSKILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u>		24a. REC'D BY REGISTRAR <u>Rockwell</u> DATE <u>NOV 30 '59</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1938

CERTIFICATE OF DEATH

1938

1

1

1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12690

Reg. Dist. No.

12727

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 4201 Dahill Road			
3. NAME OF DECEASED (Type or print) First Judith Middle Ann Last Cotter				4. DATE OF DEATH Month November Day 18 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24th, 1955		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 18 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Wash. DC.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Cotter				14. MOTHER'S MAIDEN NAME Ruth Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Cotter Address Stem 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812x Cerebral Contusions and lacerations DUE TO (b) Commminuted fracture of skull DUE TO (c) Automobile Accident CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Immediate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Immediate							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car					
20c. TIME OF INJURY Month, Day, Year Hour 2:24 a.m. 11-18 19 59 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Wheaton (County) Montg (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Bloeschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Bloeschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/21/59		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska ADDRESS WARNER E. POMPHREY, INC. SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		TIME OF BIRTH _____	
OCCUPATION _____		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		COLOR _____	
STREET ADDRESS _____		CITY _____		STATE _____	
ZIP CODE _____		COUNTY _____		DISTRICT _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PREVIOUS ILLNESSES _____		SURGICAL HISTORY _____	
MEDICATIONS _____		ALLERGIES _____		SOCIAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____		DATE OF EXAMINATION _____	
PHYSICIAN'S ADDRESS _____		MEDICAL EXAMINER'S ADDRESS _____		OFFICE OF THE MEDICAL EXAMINER _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12691

Reg. Dist. No.

12676

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6606 Westonsland Ave</u>				d. STREET ADDRESS <u>6606 Westonsland Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Albert</u> Last <u>Crawford</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>			
13. FATHER'S NAME <u>John Crawford</u>			14. MOTHER'S MAIDEN NAME <u>not available</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Alice Crawford (wife)</u> <u>Stm 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<u>History of previous heart disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-23-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Co. Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Arthur Walters</u>		ADDRESS <u>254 Carroll Manor DC</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15638

1. NAME OF DECEASED JAMES H. BOWEN		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 10/15/1963		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER [Signature]	
13. SIGNATURE OF ATTENDING PHYSICIAN [Signature]		14. SIGNATURE OF CORONER [Signature]		15. SIGNATURE OF WITNESSES [Signatures]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICIAL [Signature]	
19. SIGNATURE OF FUNERAL HOME [Signature]		20. SIGNATURE OF CEMETERY [Signature]		21. SIGNATURE OF CHURCH [Signature]	
22. SIGNATURE OF MINISTRY [Signature]		23. SIGNATURE OF OTHER [Signature]		24. SIGNATURE OF OTHER [Signature]	
25. SIGNATURE OF OTHER [Signature]		26. SIGNATURE OF OTHER [Signature]		27. SIGNATURE OF OTHER [Signature]	
28. SIGNATURE OF OTHER [Signature]		29. SIGNATURE OF OTHER [Signature]		30. SIGNATURE OF OTHER [Signature]	
31. SIGNATURE OF OTHER [Signature]		32. SIGNATURE OF OTHER [Signature]		33. SIGNATURE OF OTHER [Signature]	
34. SIGNATURE OF OTHER [Signature]		35. SIGNATURE OF OTHER [Signature]		36. SIGNATURE OF OTHER [Signature]	
37. SIGNATURE OF OTHER [Signature]		38. SIGNATURE OF OTHER [Signature]		39. SIGNATURE OF OTHER [Signature]	
40. SIGNATURE OF OTHER [Signature]		41. SIGNATURE OF OTHER [Signature]		42. SIGNATURE OF OTHER [Signature]	
43. SIGNATURE OF OTHER [Signature]		44. SIGNATURE OF OTHER [Signature]		45. SIGNATURE OF OTHER [Signature]	
46. SIGNATURE OF OTHER [Signature]		47. SIGNATURE OF OTHER [Signature]		48. SIGNATURE OF OTHER [Signature]	
49. SIGNATURE OF OTHER [Signature]		50. SIGNATURE OF OTHER [Signature]		51. SIGNATURE OF OTHER [Signature]	
52. SIGNATURE OF OTHER [Signature]		53. SIGNATURE OF OTHER [Signature]		54. SIGNATURE OF OTHER [Signature]	
55. SIGNATURE OF OTHER [Signature]		56. SIGNATURE OF OTHER [Signature]		57. SIGNATURE OF OTHER [Signature]	
58. SIGNATURE OF OTHER [Signature]		59. SIGNATURE OF OTHER [Signature]		60. SIGNATURE OF OTHER [Signature]	
61. SIGNATURE OF OTHER [Signature]		62. SIGNATURE OF OTHER [Signature]		63. SIGNATURE OF OTHER [Signature]	
64. SIGNATURE OF OTHER [Signature]		65. SIGNATURE OF OTHER [Signature]		66. SIGNATURE OF OTHER [Signature]	
67. SIGNATURE OF OTHER [Signature]		68. SIGNATURE OF OTHER [Signature]		69. SIGNATURE OF OTHER [Signature]	
70. SIGNATURE OF OTHER [Signature]		71. SIGNATURE OF OTHER [Signature]		72. SIGNATURE OF OTHER [Signature]	
73. SIGNATURE OF OTHER [Signature]		74. SIGNATURE OF OTHER [Signature]		75. SIGNATURE OF OTHER [Signature]	
76. SIGNATURE OF OTHER [Signature]		77. SIGNATURE OF OTHER [Signature]		78. SIGNATURE OF OTHER [Signature]	
79. SIGNATURE OF OTHER [Signature]		80. SIGNATURE OF OTHER [Signature]		81. SIGNATURE OF OTHER [Signature]	
82. SIGNATURE OF OTHER [Signature]		83. SIGNATURE OF OTHER [Signature]		84. SIGNATURE OF OTHER [Signature]	
85. SIGNATURE OF OTHER [Signature]		86. SIGNATURE OF OTHER [Signature]		87. SIGNATURE OF OTHER [Signature]	
88. SIGNATURE OF OTHER [Signature]		89. SIGNATURE OF OTHER [Signature]		90. SIGNATURE OF OTHER [Signature]	
91. SIGNATURE OF OTHER [Signature]		92. SIGNATURE OF OTHER [Signature]		93. SIGNATURE OF OTHER [Signature]	
94. SIGNATURE OF OTHER [Signature]		95. SIGNATURE OF OTHER [Signature]		96. SIGNATURE OF OTHER [Signature]	
97. SIGNATURE OF OTHER [Signature]		98. SIGNATURE OF OTHER [Signature]		99. SIGNATURE OF OTHER [Signature]	
100. SIGNATURE OF OTHER [Signature]		101. SIGNATURE OF OTHER [Signature]		102. SIGNATURE OF OTHER [Signature]	

James H. Bowen

12728

CERTIFICATE OF DEATH

12692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY PHILADELPHIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHILADELPHIA 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,306 GEORGIA AVENUE		d. STREET ADDRESS 2719 W. LEHIGH AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES H. CRAWFORD, SR.		4. DATE OF DEATH NOVEMBER 13 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINOTYPE MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. CRAWFORD		14. MOTHER'S MAIDEN NAME LOUISE RHODES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 164-05-7936	
17. INFORMANT CHAS. H. CRAWFORD, JR., 13,306 Ga. Ave., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Liver 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Intestinal Tract 1 year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/9/59 19____, to 11/13/59 19____, that I last saw the deceased alive on 11/13/59 19____, and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring Md DATE SIGNED 11/13/59			
ACTUAL SIGNATURE John J. Curry M.D.		PHYSICIAN'S NAME (Type) JOHN J. CURRY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY HILLSIDE CEMETERY		22d. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey Inc. Silver Spring, Md. Raymond A. Gaska		24a. REC'D BY REGISTRAR NOV 16 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hinkle			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1988



CERTIFICATE OF HEALTH

1978

1

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION



DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

SEX

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12729

CERTIFICATE OF DEATH

12693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA REST HOME		d. STREET ADDRESS 208 SLEEPY HOLLOW	
3. NAME OF DECEASED (Type or print) First Middle Last SUE R CRICHLAW		4. DATE OF DEATH Month Day Year MAR 12 1977	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BEN RANSOM		14. MOTHER'S MAIDEN NAME SUE SIMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT ROBERT W. CRICHLAW, 208 SPRING DR. FALLS CHURCH, VA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial Dis. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic myocardial Dis. DUE TO (c) thrombosed atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute viral infection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 1977 to March 12, 1977 that I last saw the deceased alive on March 11, 1977 , and that death occurred at 2:15 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers M.D.		ADDRESS (Street, city or town, state) 1917 Ramsey Rd. Falls Church, Va.	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		DATE SIGNED 20/12/77	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		22d. LOCATION (City, town, or county) (State) NASHVILLE TENN	
23. FUNERAL DIRECTOR'S SIGNATURE Ricardi Funeral Home		ADDRESS 816 H St. N.E., Wash. DC.	
24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12379

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH SHOOTING		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13830

Reg. Dist. No.

12730

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Conn. Ave. & Manor St.				d. STREET ADDRESS 1342 Ingerham St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leslie A. Cuffee First Middle Last				4. DATE OF DEATH Nov. 30, 1959 Month Day Year					
5. SEX male		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/15			
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Truck Driver			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Cuffee				14. MOTHER'S MAIDEN NAME Mildred Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) yes (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 8-12-42-17529		17. INFORMANT Harold Cole Address 3706 Jefferson Street., Hyatsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Laceration 816X DUE TO Crushed Skull Conditions, if any, which gave rise to immediate cause (b) Auto accident (c) Auto accident DUE TO Auto accident (c) Auto accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of mail truck which collided with another vehicle							INTERVAL BETWEEN ONSET AND DEATH Sudden		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of mail truck which collided with another vehicle				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 11/30 19 59 Hour 4 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Chevy Chase Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/30/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/1/59		22c. NAME OF CEMETERY OR CREMATORY Buffalo Woodford		22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Merrill Woodford				ADDRESS 1622 11th St NW		24a. REC'D BY REGISTRAR DATE DEC 9 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Travis					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 45		4. RACE White	
5. PLACE OF BIRTH New York, N.Y.		6. DATE OF BIRTH Jan. 10, 1895		7. PLACE OF DEATH Baltimore, Md.		8. DATE OF DEATH Jan. 20, 1940	
9. OCCUPATION Clerk		10. CAUSE OF DEATH Myocardial infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. Smith	
13. SIGNATURE OF NEXT OF KIN Mrs. J. H. Harris		14. ADDRESS 1234 N. Ave., Baltimore, Md.		15. TELEPHONE 1234		16. COUNTY Baltimore	
17. CITY Baltimore		18. STATE Md.		19. ZIP CODE 21201		20. COUNTY Baltimore	
21. SIGNATURE OF DECEASED JAMES J. HARRIS		22. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		23. SIGNATURE OF EXAMINER J. H. Smith		24. SIGNATURE OF DECEASED JAMES J. HARRIS	
25. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		26. SIGNATURE OF EXAMINER J. H. Smith		27. SIGNATURE OF DECEASED JAMES J. HARRIS		28. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
29. SIGNATURE OF EXAMINER J. H. Smith		30. SIGNATURE OF DECEASED JAMES J. HARRIS		31. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		32. SIGNATURE OF EXAMINER J. H. Smith	
33. SIGNATURE OF DECEASED JAMES J. HARRIS		34. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		35. SIGNATURE OF EXAMINER J. H. Smith		36. SIGNATURE OF DECEASED JAMES J. HARRIS	
37. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		38. SIGNATURE OF EXAMINER J. H. Smith		39. SIGNATURE OF DECEASED JAMES J. HARRIS		40. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
41. SIGNATURE OF EXAMINER J. H. Smith		42. SIGNATURE OF DECEASED JAMES J. HARRIS		43. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		44. SIGNATURE OF EXAMINER J. H. Smith	
45. SIGNATURE OF DECEASED JAMES J. HARRIS		46. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		47. SIGNATURE OF EXAMINER J. H. Smith		48. SIGNATURE OF DECEASED JAMES J. HARRIS	
49. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		50. SIGNATURE OF EXAMINER J. H. Smith		51. SIGNATURE OF DECEASED JAMES J. HARRIS		52. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
53. SIGNATURE OF EXAMINER J. H. Smith		54. SIGNATURE OF DECEASED JAMES J. HARRIS		55. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		56. SIGNATURE OF EXAMINER J. H. Smith	
57. SIGNATURE OF DECEASED JAMES J. HARRIS		58. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		59. SIGNATURE OF EXAMINER J. H. Smith		60. SIGNATURE OF DECEASED JAMES J. HARRIS	
61. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		62. SIGNATURE OF EXAMINER J. H. Smith		63. SIGNATURE OF DECEASED JAMES J. HARRIS		64. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
65. SIGNATURE OF EXAMINER J. H. Smith		66. SIGNATURE OF DECEASED JAMES J. HARRIS		67. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		68. SIGNATURE OF EXAMINER J. H. Smith	
69. SIGNATURE OF DECEASED JAMES J. HARRIS		70. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		71. SIGNATURE OF EXAMINER J. H. Smith		72. SIGNATURE OF DECEASED JAMES J. HARRIS	
73. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		74. SIGNATURE OF EXAMINER J. H. Smith		75. SIGNATURE OF DECEASED JAMES J. HARRIS		76. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
77. SIGNATURE OF EXAMINER J. H. Smith		78. SIGNATURE OF DECEASED JAMES J. HARRIS		79. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		80. SIGNATURE OF EXAMINER J. H. Smith	
81. SIGNATURE OF DECEASED JAMES J. HARRIS		82. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		83. SIGNATURE OF EXAMINER J. H. Smith		84. SIGNATURE OF DECEASED JAMES J. HARRIS	
85. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		86. SIGNATURE OF EXAMINER J. H. Smith		87. SIGNATURE OF DECEASED JAMES J. HARRIS		88. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
89. SIGNATURE OF EXAMINER J. H. Smith		90. SIGNATURE OF DECEASED JAMES J. HARRIS		91. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		92. SIGNATURE OF EXAMINER J. H. Smith	
93. SIGNATURE OF DECEASED JAMES J. HARRIS		94. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		95. SIGNATURE OF EXAMINER J. H. Smith		96. SIGNATURE OF DECEASED JAMES J. HARRIS	
97. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		98. SIGNATURE OF EXAMINER J. H. Smith		99. SIGNATURE OF DECEASED JAMES J. HARRIS		100. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12694

12731
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. LENGTH OF STAY IN 1b 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REST HAVEN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ALICE Last CUMMINGS		4. DATE OF DEATH Month NOV. Day 24 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1875
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. MOORE		14. MOTHER'S MAIDEN NAME KATHERINE E. TIPPETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Joseph B. Moore, 11,818 Huggins Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CITROMIC RENAL FAILURE WITH GRIEMIA 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 YEARS 10 YEARS 20 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARTIAL LARGE BOWEL OBSTRUCTION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 1959 , to Nov. 24, 1959 , that I last saw the deceased alive on Nov. 23, 1959 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 North Summit Ave Gaithersburg, Maryland DATE SIGNED Nov 24/59			
ACTUAL SIGNATURE Jordan S. Rosenberger		DATE SIGNED Nov 24/59	
PHYSICIAN'S NAME (Type) JORDON S. ROSENBERGER		DATE SIGNED Nov 24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/28/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPERY, INC. Raymond A. Zuka		24a. REC'D BY REGISTRAR DATE NOV 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE PAY DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH TIME OF BURIAL PLACE OF BURIAL NAME OF FUNERAL HOME NAME OF MINISTER NAME OF CHURCH NAME OF CEMETERY NAME OF INTERVIEWER NAME OF REPORTER NAME OF REGISTRAR NAME OF CLERK NAME OF ASSISTANT CLERK NAME OF CHIEF CLERK NAME OF DEPUTY CLERK NAME OF SECRETARY NAME OF ASSISTANT SECRETARY NAME OF CHIEF OF BUREAU NAME OF DEPUTY CHIEF OF BUREAU NAME OF ASSISTANT CHIEF OF BUREAU NAME OF CHIEF OF DIVISION NAME OF DEPUTY CHIEF OF DIVISION NAME OF ASSISTANT CHIEF OF DIVISION NAME OF CHIEF OF SECTION NAME OF DEPUTY CHIEF OF SECTION NAME OF ASSISTANT CHIEF OF SECTION NAME OF CHIEF OF UNIT NAME OF DEPUTY CHIEF OF UNIT NAME OF ASSISTANT CHIEF OF UNIT NAME OF CHIEF OF BRANCH NAME OF DEPUTY CHIEF OF BRANCH NAME OF ASSISTANT CHIEF OF BRANCH NAME OF CHIEF OF OFFICE NAME OF DEPUTY CHIEF OF OFFICE NAME OF ASSISTANT CHIEF OF OFFICE NAME OF CHIEF OF DIVISION NAME OF DEPUTY CHIEF OF DIVISION NAME OF ASSISTANT CHIEF OF DIVISION NAME OF CHIEF OF SECTION NAME OF DEPUTY CHIEF OF SECTION NAME OF ASSISTANT CHIEF OF SECTION NAME OF CHIEF OF UNIT NAME OF DEPUTY CHIEF OF UNIT NAME OF ASSISTANT CHIEF OF UNIT NAME OF CHIEF OF BRANCH NAME OF DEPUTY CHIEF OF BRANCH NAME OF ASSISTANT CHIEF OF BRANCH NAME OF CHIEF OF OFFICE NAME OF DEPUTY CHIEF OF OFFICE NAME OF ASSISTANT CHIEF OF OFFICE	
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CERTIFICATE OF DEATH

12695

Reg. Dist. No.

12732

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>821-University Blvd. East</u>				d. STREET ADDRESS <u>821-University Blvd East</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETTA FRANCES CURTIS</u>				4. DATE OF DEATH Month Day Year <u>11 25 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1866</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN GROFF</u>				14. MOTHER'S MAIDEN NAME <u>ELVIRA ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>48</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>8:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Bernard A. D'Aguala</u> M.D. <u>217 University Blvd E.</u> <u>11-25-59</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11/28/59</u>		<u>MT. OLIVET</u>		<u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Timothy Hanlon - 3831-GA AVENUE</u>				<u>DEC 7 '59</u>		<u>Arthur S. Hume</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

NAME OF DECEASED JAMES H. SMITH		SEX Male	
AGE 45		DATE OF BIRTH Jan 15, 1880	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE May 10, 1905	
NAME OF SPOUSE Mary E. Smith		PLACE OF MARRIAGE Baltimore, Md.	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH Dec 10, 1925		TIME OF DEATH 10:30 AM	
PLACE OF DEATH 1234 Main St.		NAME OF PHYSICIAN Dr. J. B. Jones	
NAME OF FUNERAL HOME Smith & Sons		DATE OF BURIAL Dec 15, 1925	
PLACE OF BURIAL St. Mary's Cemetery		NAME OF MINISTER Rev. W. H. Brown	
NAME OF NEXT OF KIN John H. Smith		ADDRESS OF NEXT OF KIN 5678 Elm St.	
CITY OF NEXT OF KIN Baltimore, Md.		STATE OF NEXT OF KIN Maryland	
NAME OF WITNESS John H. Smith		ADDRESS OF WITNESS 5678 Elm St.	
CITY OF WITNESS Baltimore, Md.		STATE OF WITNESS Maryland	
NAME OF REGISTRAR J. B. Jones		ADDRESS OF REGISTRAR 1234 Main St.	
CITY OF REGISTRAR Baltimore, Md.		STATE OF REGISTRAR Maryland	



THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED.

12733

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle Last DAVIES				4. DATE OF DEATH Month November Day 17 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0 Days 23	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptroller		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Loth		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Davies				14. MOTHER'S MAIDEN NAME Elizabeth Kirkwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		INFORMANT Address Robert Davies-Brother-Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 50 , to Nov 17 , 19 59 , that I last saw the deceased alive on Nov 17 , 19 59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John O. Schreiber M.D. Nov 17 1959							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) John O. Schreiber 1716 Rhode Island Ave., N.W., Wash. D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE NOV 20 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1876

CERTIFICATE OF DEATH

1876

INTESTATE

DECEASED

CHURCH HOSPITAL

JOHN

WATTS

10-24-1870

Wife

Longsight

Wood and A. Longsight, G. O.

Missed in 1870

Missed in 1870

Room of number 1000-1870

Longsight, G. O.

Longsight, G. O.

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Longsight, G. O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12698

12734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Nursing Home		d. STREET ADDRESS 7111 13th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Montgomery First Middle Last Davis		4. DATE OF DEATH Month November Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10 1874
9. AGE (In years lost birthday) yrs. 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Montillion Davis		14. MOTHER'S MAIDEN NAME Elizabeth Herndon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. E. E. Santemma		Address 500 Front St L.I. N.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Uremia 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Renal Shutdown DUE TO (c) Gastrointestinal Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH One Week Two Days Four Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 9 19 59 , to Nov 10 19 59 , that I last saw the deceased alive on Nov 9 19 59 , and that death occurred at 2:50 a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Maryland	
DATE SIGNED Nov 10, 1959			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12 1959	
22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		22d. LOCATION (City, town, or county) (State) Stafford County Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. N.W. D.C.	
24a. REC'D BY REGISTRAR NOV 12 '59		24b. REGISTRAR'S SIGNATURE Catharine S. K...	

12735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 114 days				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York				b. COUNTY 69x-3				c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Belle Harbor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Harry				Middle (None)				Last Deutsch				4. DATE OF DEATH Month November				Day 11				Year 1959																			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH January 19, 1911				9. AGE (In years lost birthday) 48 yrs.				IF UNDER 1 YEAR Months 48				IF UNDER 24 HRS. Days 48				Hours 48				Min. 48							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist								10b. KIND OF BUSINESS OR INDUSTRY Dental								11. BIRTHPLACE (State or foreign country) New York								12. CITIZEN OF WHAT COUNTRY? U. S. A.															
13. FATHER'S NAME Morris Deutsch												14. MOTHER'S MAIDEN NAME Naomi Yagour																											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. 976-32-3034								INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 134.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Endocarditis DUE TO (c) Candida Guilliermondi																INTERVAL BETWEEN ONSET AND DEATH Immediate 6 months 6 months																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from July 20, 1959 , to November 11, 1959 , that I last saw the deceased alive on November 11, 1959 , and that death occurred at 6:10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 11/11/59																																							
ACTUAL SIGNATURE Howard M. Kravetz												M.D. The Clinical Center																											
PHYSICIAN'S NAME (Type) Howard M. Kravetz, M.D.												National Institutes of Health Bethesda 14, Maryland																											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL								22b. DATE THEREOF 11-13-59								22c. NAME OF CEMETERY OR CREMATORY WELLWOOD CEMETERY								22d. LOCATION (City, town, or county) (State) PINELAWN, L.I., N.Y.															
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS												ADDRESS 3501-14th St. N.W.												24a. REC'D BY REGISTRAR DATE NOV 13 1959								24b. REGISTRAR'S SIGNATURE C. J. King							

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

112700

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12736

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS 705 North Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Clayton Jr. DIXON			4. DATE OF DEATH Month Day Year November 8 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-42	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana			
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Clayton DIXON SR.			14. MOTHER'S MAIDEN NAME Marion RAMSEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address (Father) George C. Dixon Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 744.1 Congestive Heart Failure DUE TO (b) Myocarditis DUE TO (c) Muscular Dystrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Muscular Dystrophy							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda Md.			
20f. (City or town) Arlington Va.		(County)		(State)			
21. I certify that I attended the deceased from 7 November , 19 59 , to 8 November , 19 59 , that I last saw the deceased alive on 8 November , 19 59 , and that death occurred at 3:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-9-59							
ACTUAL SIGNATURE Kenneth M. Moser		M.D. U.S. Naval Hospital, Bethesda Md. 11-9-59					
PHYSICIAN'S NAME (Type) K.M. MOSER LT MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington Va.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7551 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '59			
24b. REGISTRAR'S SIGNATURE Arthur E. Knead							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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2007-08-01

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda, Md.

12737

CERTIFICATE OF DEATH

Reg. Dist. No.

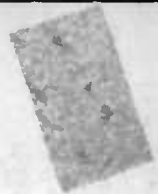
1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX SUBURBAN HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
f. STREET ADDRESS 1421 CRESTRIDGE DRIVE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael R Middle Dobridge Last SR		4. DATE OF DEATH Month Nov. Day 9 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/96
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Embroidery		10b. KIND OF BUSINESS OR INDUSTRY Garment Industry	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARK DOBRIDGE		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII 152-09-5445	
17. INFORMANT Dr. Michael R. Dobridge, 1421 Crestridge Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 1-2 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1952 to Nov 9 1959 , that I last saw the deceased alive on Nov 9 1959 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Sharpe		ADDRESS (Street, city or town, state) 10511 Summit Ave Kensington, Md.	
PHYSICIAN'S NAME (Type) George Sharpe		DATE SIGNED 11/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS & BURIAL		22b. DATE THEREOF 11/10/59	
22c. NAME OF CEMETERY OR CREMATORY MADONNA CEMETERY		22d. LOCATION (City, town, or county) (State) FORT LEE, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zuka		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
24b. REGISTRAR'S SIGNATURE Carlton L. Kline			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of first death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12737



1



[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and cause of death.]

CERTIFICATE OF DEATH

Reg. Dist. No.

12738

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>15 days 15 1/2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER C.</u> Middle <u>DRURY</u> Last <u>SR.</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Samuel Drury</u>				14. MOTHER'S MAIDEN NAME <u>Alice Matilda Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-01-5589</u>		INFORMANT <u>WALTER C. DRURY JR.</u> Address <u>3819 BENTON ST. N.W. WASHINGTON 7, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of Pancreas</u> DUE TO (c) <u>3 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>51</u> , to <u>Nov 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>59</u> , and that death occurred at <u>5:05</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u>				ADDRESS (Street, city or town, state) <u>M.D. 1110 Georgia Ave., Silver Spring Md</u> DATE SIGNED <u>11/15/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. L. Avery</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>24. Don. De Sol</u>				ADDRESS <u>2224-Wis Ave</u>		24a. REC'D BY REGISTRAR <u>NOV 20 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12703

12697

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11916 Maple Avenue		d. STREET ADDRESS 11916 Maple Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle THOMAS Last DULEY		4. DATE OF DEATH Month Nov. Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 21	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas Duley		14. MOTHER'S MAIDEN NAME Susie Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-8622	
17. INFORMANT Mrs. Maywood Cross-daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of 191.4 DUE TO skin of neck with generalized Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) metastases DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 18 , 19 59 , to Nov. 4 , 19 59 , that I last saw the deceased alive on Nov. 4 , 19 59 , and that death occurred at 6:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur F. Woodward		DATE SIGNED 11/4/59	
PHYSICIAN'S NAME (Type) Arthur F. Woodward		ADDRESS (Street, city or town, state) 41 West Wood Lane, Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/59	
22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12704

Reg. Dist. No.

12739

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>11600 EAST WEST HWY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>JULIAN SANFORD Egre</u> First Middle Last				4. DATE OF DEATH <u>NOV. 15</u> 19 <u>59</u> Month Day Year													
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18, 1909</u>		9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER U.S. Gov't. Fed. Trade Comm.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WISCONSIN</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>STEPHEN J. Egre</u>						14. MOTHER'S MAIDEN NAME <u>Hilda Briden Rinden</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes W.W.#2 & Korean</u>						16. SOCIAL SECURITY NO. <u>577-54-4756</u>						17. INFORMANT <u>Elinor G. Egre</u> Address <u>Stem 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>1:30 P.M. 11-15-59</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington County, Virginia</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>						24a. REC'D BY REGISTRAR <u>Raymond A. Jaska</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							
DATE <u>NOV 18 '59</u>						DATE <u>NOV 18 '59</u>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18-588

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "10-15-1918"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CITY [Faint text, possibly "Baltimore"]	
COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]			
CAUSE OF DEATH [Faint text, possibly "Heart failure"]			
MANNER OF DEATH [Faint text, possibly "Natural"]			
SIGNATURE OF MEDICAL EXAMINER [Faint signature]			
DATE OF SIGNATURE [Faint text, possibly "10-15-1918"]			
SIGNATURE OF WITNESS [Faint signature]			
DATE OF SIGNATURE [Faint text, possibly "10-15-1918"]			

ADDITIONAL INFORMATION: [Faint vertical text on the right margin]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12705

Reg. Dist. No.

12740

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 3450 38th Street, N.W.	
3. NAME OF DECEASED (Type or print) First Eva Middle Last Evans		4. DATE OF DEATH Month November Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Downs		14. MOTHER'S MAIDEN NAME Ramsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Ruth E. Perry - 3450 - 38th. St., N. W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra peritoneal hemorrhage DUE TO 900.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture of liver DUE TO (c) Fall down stairs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down a flight of stairs	
20c. TIME OF INJURY Month, Day, Year Hour 3 p. m. 11-27 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Washington (County) DC (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 11-30-59	
EXAMINER'S NAME (Type) FRANK J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/3/59	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.	22d. LOCATION (City, town, or county) Washington (State) DC
23. FUNERAL DIRECTOR'S SIGNATURE Chas. Lane Funeral Home		24a. REC'D BY REGISTRAR DEC 2 '59	
ADDRESS Washington		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12741

CERTIFICATE OF DEATH

12706
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Watters Last EWING		4. DATE OF DEATH Month November Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-02
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Watters EWING		14. MOTHER'S MAIDEN NAME Emily LITTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236 50 8861	
17. INFORMANT (Wife) Mrs. Paula Ewing Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) Chronic Pyelonephritis + Hydronephrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years 10 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 October , 19 59 , to 2 November , 19 59 , that I last saw the deceased alive on 2 November , 19 59 , and that death occurred at 10:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-8-59			
ACTUAL SIGNATURE F.H. O'Connell		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) F.H. O'CONNELL LCDR MC USN		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-59	
22c. NAME OF CEMETERY OR CREMATORY Stinger Hill		22d. LOCATION (City, town, or county) (State) Fort Loudin Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR NOV 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		24c. ADDRESS 7557 Wisconsin Ave. Bethesda Md.	

1974

CENTRAL AIR OF TEXAS

12

Investigation of the death of a person in the State of Texas

Referred to (Name) 10 days

U.S. Naval Hospital, Bethesda, Md. 22 months

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12707

12742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN IB 12 Hrs., 50 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock 21X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 323 Myers Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle ARTHUR Last FAITH				4. DATE OF DEATH Month November Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1915 44	
9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Erastus Faith				14. MOTHER'S MAIDEN NAME Bertha Barnhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-0148		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.7 DUE TO Increased Intracranial Pressure leading to pressure cone & Respiratory Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Malignant Melanoma of the Right Parietal Frontal Lobe of the Brain. (c) Malignant Melanoma of the Left Calf.				INTERVAL BETWEEN ONSET AND DEATH 24 Hours 1 Month 23 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 7, 1959 , to November 7, 1959 , that I last saw the deceased alive on November 7, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Seymour C. Nash M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-8-59			
PHYSICIAN'S NAME (Type) SEYMOUR C. NASH, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11.10.59		22c. NAME OF CEMETERY OR CREMATORY House of Jacob Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone				ADDRESS Hancock Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1972

File No. 10

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
JAMES EARL RAY		5-1-41		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Memphis, Tenn.		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Age at Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
27 years		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Date of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
5-6-68		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Time of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10:00 PM		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Signature of Physician		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Edgar Hoover		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	
Signature of Registrar		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Edgar Hoover		5-6-68		M		W		Single		Actor		Heart Disease		Baltimore, Md.		5-6-68		10:00 PM		J. Edgar Hoover		J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677

CERTIFICATE OF DEATH

Reg. Dist. No.

12708

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>8520-Greenwood Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Christina</u> Middle <u>Taman</u> Last <u>Fajen</u>				4. DATE OF DEATH <u>11</u> Month <u>28</u> Day <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-59</u>	
9. AGE (In years last birthday) yrs. <u>28</u>		IF UNDER 1 YEAR Months <u>28</u>		IF UNDER 24 HRS. Hours <u>28</u> Min. <u>28</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clifford Walter Fajen</u>				14. MOTHER'S MAIDEN NAME <u>Lucielle Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chant Clifford Fajen</u> Address <u>8520 Greenwood Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-30</u> , 19 <u>59</u> , to <u>11-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-27</u> , 19 <u>59</u> , and that death occurred at <u>8:23</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.				ADDRESS (Street, city or town, state) <u>927 Pershing Ave, Sil. Spg, Md</u>			
PHYSICIAN'S NAME (Type) <u>Winston E Cochran</u>				DATE SIGNED <u>11-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co.</u> ADDRESS <u>1400 Chapin St NW, N.W.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

2075242XU1

CERTIFICATE OF DEATH

12577

DATE OF DEATH

PLACE OF DEATH

HABIT

USUAL RESIDENCE

CAUSE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

DO NOT SIGN HERE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 12709													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>Blue Ridge Road</u>								
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Feldbush</u>					4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1959</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/03</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Canton, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John W. Feldbush</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Mock</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-09-9526</u>		17. INFORMANT Address <u>Mr. Parsons - 602 East St., S. S. Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Contusion & Subdural Hemorrhage</u> <u>900.0</u> DUE TO <u>Fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down basement steps at home</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> <u>10-23</u> <u>1959</u> a.m. <u> </u> p.m. <u> </u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Wheaton</u>		(County) <u>montgomery</u>		(State) <u>md</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>11/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>					ADDRESS <u>SILVER SPRING, MD.</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE	
John V. Williams		Male		45		White		Farmer		Maryland		1918		10		10		Heart Disease		Natural		J. V. Williams		1918	
14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS	

CERTIFICATE OF DEATH

Reg. Dist. No.

12744

12710

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2 Prospect Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KEVIN Middle MICHAEL Last FLATTERY		4. DATE OF DEATH Month November Day 6 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1946				
9. AGE (In years last birthday) yrs. 13		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 83 Days x Hours - Min. 3					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none					
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Matthew Flattery		14. MOTHER'S MAIDEN NAME Adele Viningre					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none					
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL INFECTION DUE TO (c) 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from November 2, 1959 , to November 6, 1959 , that I last saw the deceased alive on November 6, 1959 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Steven Schenker M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-7-59					
PHYSICIAN'S NAME (Type) STEVEN SCHENKER, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59					
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia.					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Demaine & Son Funeral Home, Alexandria, Va.		24a. REC'D BY REGISTRAR NOV 12 '59					
24b. REGISTRAR'S SIGNATURE Arthur S. Kram							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The following names, addresses, etc.,
 are being furnished to you for information.
 Name: [Name] Address: [Address]
 City: [City] State: [State] Zip: [Zip]
 Date: [Date]

no other info.

The following names, addresses, etc.,
 are being furnished to you for information.
 Name: [Name] Address: [Address]
 City: [City] State: [State] Zip: [Zip]
 Date: [Date]

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12745

12711

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maine b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 14 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			d. STREET ADDRESS 31 South Stanwood Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Laura Middle Lucile Last FOLSOM			4. DATE OF DEATH Month November Day 17 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-55		9. AGE (In years last birthday) 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Riley T. FOLSOM			14. MOTHER'S MAIDEN NAME Eudora ISBELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
INFORMANT (Father) Riley T. Folsom			Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medulloblastoma 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 28 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3 November , 19 59 , to 17 November , 19 59 that I last saw the deceased alive on 17 November , 19 59 , and that death occurred at 4:45 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W.H. Druckemiller		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 11-18-9			
DATE SIGNED 11-18-59					
PHYSICIAN'S NAME (Type) W.H. DRUCKEMILLER CAPT MC USN		U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE NOV 19 59	24b. REGISTRAR'S SIGNATURE Arthur J. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944

COMMUNIST PARTY

NAME

RESIDENCE

DATE

IN CASE

REMARKS (initial)

U.S. Naval Hospital, Bethesda Md.

51 South Street, Boston

FOOT

LEGS

ARM

3-2-52

WHITE

FOOT

Washington

FOOT

FOOT

RAY T. FOLSON

WASH DC

(Father) RAY T. FOLSON, born 12

FOOT

FOOT

12698

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 620 Great Falls Road Rockville Road				c. LENGTH OF STAY IN 1b 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 620 Great Falls Road				1 d. STREET ADDRESS 620 Great Falls Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BIRDIE VIOLA FORMWALT		First Middle Last		4. DATE OF DEATH Nov. 16 1959		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1876		9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months 1 Days 6	IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John N. Mark				14. MOTHER'S MAIDEN NAME Augusta J. Morelock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mary V. deVermond-daughter-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO (b) essential hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 9 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Nov. 13, 1957 to Nov. 16, 1959 , that I last saw the deceased alive on Nov. 16, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen C. Cromwell M.D.				ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.		DATE SIGNED 10/16/59	
PHYSICIAN'S NAME (Type) Stephen C. Cromwell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/59		22c. NAME OF CEMETERY OR CREMATORY East Harrisburg Cem.		22d. LOCATION (City, town, or county) (State) Harrisburg, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 18 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. Kline			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13832

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

12746

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg d. STREET ADDRESS 201 Lee Street Apt. 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doreen Middle (n) Last FOSTER		4. DATE OF DEATH Month November Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-05
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 54 Days 25 Hours 1959	11. IF UNDER 24 HRS. Months 54 Days 25 Hours 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) India
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Frederick REGNAUD		14. MOTHER'S MAIDEN NAME Violet VAUGHN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT (Husband) Francis Foster Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Carcinomatosis DUE TO (b) Carcinoma of Stomach DUE TO (c) 1 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 November 1959 to 25 November 1959 , that I last saw the deceased alive on 25 November 1959 , and that death occurred at 8:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE C. U. Bramlett		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-25-59	
PHYSICIAN'S NAME (Type) C. U. BRAMLETT LT MC USN		U.S. Naval Hospital, NNMC, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 11-27-59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Prince George County
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS 1331 E. Montgomery Ave. Rockville		24a. REC'D BY REGISTRAR NOV 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12345

12345

Hatchfield (R. 101)

13 days

Col. Hatchfield

U.S. Naval Hospital, Honolulu, HI.

Red Sea Hospital, Egypt

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(a)

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White

3-7-55

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(Hatchfield) 12345

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U.S. Naval Hospital, Honolulu, HI.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

127714

12747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney - Rural		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE JEANNETTE FRANKLIN		4. DATE OF DEATH November 17, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry High		14. MOTHER'S MAIDEN NAME Sarah Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Dorothy Leef-Item #2-Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic heart disease. (c) and Chronic pulmonary emphysema.		INTERVAL BETWEEN ONSET AND DEATH 5/10/1959 - 11/17/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-14-59 , 19 59 , to 11-17-59 , 19 59 , that I last saw the deceased alive on 11-17-59 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) November 18, 1959 DATE SIGNED George A. Gray, Jr., M.D. M.D. 4422 East West Highway, Bethesda 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-18-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

CERTIFICATE OF DEATH

1270

1270

City of Chicago

County of Cook

1007 East Avenue

Chicago, Illinois

November 12, 1917

Age 45 years

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Barron R. Franklin</u>		4. DATE OF DEATH <u>Nov-24 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12-1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James S. Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Alice Rebecca Barron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Dorothy F. Leef-daughter-same as 2d</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Diabetes Mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 11 1957</u> to <u>Nov 24 1959</u> , that I last saw the deceased alive on <u>Nov 3 1959</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Ligor</u> M.D.		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>11/24/59</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Ligor</u>		22. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>11-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William L. Hays</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

CERTIFICATE OF DEATH

1900

NAME OF DECEASED		SEX		AGE	
JAMES E. FRANK		Male		37	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		JAN 3 1900		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HEART DISEASE		NATURAL		LABORER	
MEDICAL ATTENDANT		BURIAL		CITY	
DR. J. H. BROWN		CATHOLIC		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
		J. H. BROWN		J. H. BROWN	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
JAN 3 1900		JAN 3 1900		JAN 3 1900	

Dec. 3 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12716

12749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 32 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5331 Chamberlin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MORRISON Middle BRADY Last FRENCH		4. DATE OF DEATH Month November Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1885
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 11 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Supt.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William French		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 578-20-9947	
17. INFORMANT Ethel C. French- Wife - Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Instant. 6 month 3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-13- 19 59 to 10-3- 19 59 , that I last saw the deceased alive on 10-7- 19 59 , and that death occurred at 7:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis T. Sharpe M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3323- O. St. N. W. Wash. D.C. 10C	
PHYSICIAN'S NAME (Type) Francis T. Sharpe, M. D.		3323- O. St. N. W. Wash. D. C.	
22a. BURIAL, CREMATION, REMOVAL, ETC. Cremation		22b. DATE THEREOF 11-5-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 6 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

12345

CERTIFICATE OF DEATH

Montgomery

Bethesda

32 years

Bethesda

3251 Columbia Avenue

3251 Columbia Avenue

WILLIAM BRADY

WILLIAM

November 1, 1982

Nov. 1, 1982

Retired

Washington, D. C.

William French

Unknown

Nov. 1, 1982

3251 Columbia Avenue, Bethesda - Male - 32

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12717

12750

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days 2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			d. STREET ADDRESS <u>5908 Aberdeen Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Harrison</u> Last <u>Gannaway</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 - 9 - 1892</u>		9. AGE (In years last birthday) <u>67 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Film Technologist (retired) Lib. of Cong.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G annaway</u>			14. MOTHER'S MAIDEN NAME <u>M ary Bouvet</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>March '17-Jan. '19 None</u>		INFORMANT Address <u>Louise P. Gannaway 5908 Aberdeen RD. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral confluent bronchopneumonia</u> DUE TO (b) <u>Esophago-bronchial fistulae</u> DUE TO (c) <u>Bronchogenic carcinoma, post irradiation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 DAYS</u> <u>UNDETERMINED</u> <u>60 DAYS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7720 Wisconsin Ave Bethesda 14, Md.</u>	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>ABOUT 9/1/1959</u> to <u>NOV. 12, 1959</u> , that I lost the deceased alive on <u>11/12, 1959</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Tuohy</u>		M.D. <u>7720 Wisconsin Ave Bethesda 14, Md.</u>		DATE SIGNED <u>11/14/59</u>	
PHYSICIAN'S NAME (Type) <u>John H. Tuohy - 7720 Wisconsin Ave., Bethesda 14, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			
ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Haus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

101



101

John H. Tully
John H. Tully
John H. Tully

John H. Tully
John H. Tully

John H. Tully - The above named person died on the 21st day of

John H. Tully - The above named person died on the 21st day of

12751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Sanitarium & Hosp</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Takoma Park Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Esther</u> Middle <u>Nancy</u> Last <u>Ganong</u>		Month <u>Nov.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. C.</u>	
13. FATHER'S NAME <u>Joseph Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Estella Plemons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small Bowel Obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Internal Mesenteric Strangulated hernia</u> (c) <u>Adhesions from previous Surgery</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>15-20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>59</u> , to <u>Nov. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 18</u> , 19 <u>59</u> , and that death occurred at <u>5:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u> DATE SIGNED <u>11/19/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 23, 1959</u>	<u>Memorial Park</u>	<u>Memphis Tennessee</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	
ADDRESS <u>254 Carroll Street N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1882



CERTIFICATE OF DEATH

Reg. Dist. No.

12752

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION 6607 Marywood Road				d. STREET ADDRESS 6607 Marywood Road			
3. NAME OF DECEASED (Type or print) First Regis Middle F. Last George				4. DATE OF DEATH Month 11 Day 18 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1908		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 5 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Navy Dept.		11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Walter J. George				14. MOTHER'S MAIDEN NAME Clara Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-22-3542		INFORMANT Regina George-wife-same as 2d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Metastatic Carcinoma DUE TO Primary Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 M. (c)						INTERVAL BETWEEN ONSET AND DEATH 6 M.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1958 to Nov 18, 1959 , that I last saw the deceased alive on Nov 17, 1959 , and that death occurred at 11:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Geo I Donovan M.D.				ADDRESS (Street, city or town, state) 6016 Kensington Road Bethesda 14 Maryland			
PHYSICIAN'S NAME (Type) Geo I Donovan M.D.				DATE SIGNED 11/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/20/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Green Lawn		22d. LOCATION (City, town, or county) (State) Hollidaysburg, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1935

W

1

THE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED: GEORGE J. BROWN

DATE OF DEATH: SEPTEMBER 15, 1935

PLACE OF DEATH: AT HOME

AGE: 45 YEARS

SEX: MALE

RACE: WHITE

BIRTH: APRIL 10, 1890

PLACE OF BIRTH: NEW YORK

OCCUPATION: CLERK

CAUSE OF DEATH: HEART DISEASE

IMMEDIATE CAUSE: MYOCARDIAL INFARCTION

PREVAILING DISEASE: ARTERIOSCLEROSIS

DATE OF INTERMENT: SEPTEMBER 17, 1935

PLACE OF INTERMENT: CATHARTIC CEMETERY

SIGNATURE OF PHYSICIAN: JOHN J. SMITH

SIGNATURE OF REGISTRAR: JOHN J. SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720

12753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Havarest Nursing Home</u>		d. STREET ADDRESS <u>1327 - Monroe St. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>ISABEL</u> First <u>C</u> Middle <u>GLADDING</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 10-1869</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>
13. FATHER'S NAME <u>Benjamin Newton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Greer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT Address <u>Lois Wagner - 1327 Monroe St N.E. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 9, 1959</u> , to <u>Nov. 9, 1959</u> , that I last saw the deceased alive on <u>Nov. 9, 1959</u> , and that death occurred at <u>2:02 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u> M.D.		ADDRESS (Street, city or town, state) <u>918 University Blvd. E.</u> DATE SIGNED <u>11/9/59</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>11-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home.</u> ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

CERTIFICATE OF DEATH

12753

Form 302 Rev. 1-60

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. ZIP CODE	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. OCCUPATION		12. MARITAL STATUS	
13. CAUSE OF DEATH		14. MANNER OF DEATH	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. DATE OF SIGNATURE		18. TIME OF SIGNATURE	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS	
23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS	
27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12721

12754

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 95 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The /Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY The District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X - 3 d. STREET ADDRESS 4815 North Capitol Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) SIDNEY		First SIDNEY		Middle --		Last GLICK		4. DATE OF DEATH Month November		Day 17,		Year 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 15, 1895		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Paper Company		11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jacob Glick						14. MOTHER'S MAIDEN NAME Sara (unknown)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 100-03-5180		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to brain DUE TO Carcinoma of prostate gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 177X (c) 2 1/2 yrs.												INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from August 14, 1959 , to November 17, 1959 , that I last saw the deceased alive on November 17, 1959 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-17-59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland													
ACTUAL SIGNATURE Gordon C. Sharp				M.D.		PHYSICIAN'S NAME (Type) Gordon C. Sharp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/19-1959		22c. NAME OF CEMETERY OR CREMATORY Geowash Cem				22d. LOCATION (City, town, or county) (State) Nyassville Md			
23. FUNERAL DIRECTOR'S SIGNATURE Baldern Funeral Home						ADDRESS 4217 9th NW		24a. REC'D BY REGISTRAR DATE NOV 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kama			

CERTIFICATE OF DEATH

13754

The first of October

1902

1902

His name is [illegible]

born [illegible]

aged [illegible]

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CERTIFICATE OF DEATH

Reg. Dist. No.

12722

12755

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>"</u>	
c. LENGTH OF STAY IN 1b <u>1 wk.</u>		d. STREET ADDRESS <u>808 Madison St. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4604 S. Chelsea Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary J. Quinlan Gwynne</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/29/1870 (?)</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seamstress</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Quinlan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hanlon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>"</u>	
17. INFORMANT <u>S. E. Proctor</u> Address <u>4604 S. Chelsea Lane Bethesda, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic-hypertensive heart disease.</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>54</u> to <u>NOV 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>59</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>William F Simpson, Jr.</u> M.D. <u>6216 N.H. Ave. N.E.</u>		<u>11/10/59</u>	
PHYSICIAN'S NAME (Type) <u>William F Simpson Jr.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/13/59</u>	<u>Mt. Olivet</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Frank Seiers Sons Co</u>		<u>NOV 13 '59</u>	<u>Arthur S. Hanks</u>
ADDRESS <u>3605-14 St NW</u>		<u>Wash. D.C.</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12528

12528

<p>1. Name of deceased: <u>JOHN A. WILSON</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1910</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1960</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1960</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>JOHN A. WILSON</u></p>		<p>14. Address of informant: <u>NEW YORK</u></p>	
<p>15. Name of informant: <u>JOHN A. WILSON</u></p>		<p>16. Address of informant: <u>NEW YORK</u></p>	
<p>17. Name of informant: <u>JOHN A. WILSON</u></p>		<p>18. Address of informant: <u>NEW YORK</u></p>	
<p>19. Name of informant: <u>JOHN A. WILSON</u></p>		<p>20. Address of informant: <u>NEW YORK</u></p>	
<p>21. Name of informant: <u>JOHN A. WILSON</u></p>		<p>22. Address of informant: <u>NEW YORK</u></p>	
<p>23. Name of informant: <u>JOHN A. WILSON</u></p>		<p>24. Address of informant: <u>NEW YORK</u></p>	
<p>25. Name of informant: <u>JOHN A. WILSON</u></p>		<p>26. Address of informant: <u>NEW YORK</u></p>	
<p>27. Name of informant: <u>JOHN A. WILSON</u></p>		<p>28. Address of informant: <u>NEW YORK</u></p>	
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<p>35. Name of informant: <u>JOHN A. WILSON</u></p>		<p>36. Address of informant: <u>NEW YORK</u></p>	
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<p>79. Name of informant: <u>JOHN A. WILSON</u></p>		<p>80. Address of informant: <u>NEW YORK</u></p>	
<p>81. Name of informant: <u>JOHN A. WILSON</u></p>		<p>82. Address of informant: <u>NEW YORK</u></p>	
<p>83. Name of informant: <u>JOHN A. WILSON</u></p>		<p>84. Address of informant: <u>NEW YORK</u></p>	
<p>85. Name of informant: <u>JOHN A. WILSON</u></p>		<p>86. Address of informant: <u>NEW YORK</u></p>	
<p>87. Name of informant: <u>JOHN A. WILSON</u></p>		<p>88. Address of informant: <u>NEW YORK</u></p>	
<p>89. Name of informant: <u>JOHN A. WILSON</u></p>		<p>90. Address of informant: <u>NEW YORK</u></p>	
<p>91. Name of informant: <u>JOHN A. WILSON</u></p>		<p>92. Address of informant: <u>NEW YORK</u></p>	
<p>93. Name of informant: <u>JOHN A. WILSON</u></p>		<p>94. Address of informant: <u>NEW YORK</u></p>	
<p>95. Name of informant: <u>JOHN A. WILSON</u></p>		<p>96. Address of informant: <u>NEW YORK</u></p>	
<p>97. Name of informant: <u>JOHN A. WILSON</u></p>		<p>98. Address of informant: <u>NEW YORK</u></p>	
<p>99. Name of informant: <u>JOHN A. WILSON</u></p>		<p>100. Address of informant: <u>NEW YORK</u></p>	

JOHN A. WILSON

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/1/00 BY 60322 UCBAW/STP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12723

Reg. Dist. No.

12755

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8662 Piney Branch Rd - Apt 303</u>				d. STREET ADDRESS <u>8662 Piney Br. Rd - Apt 303</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Col. Donald Herbert Hale</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-7-01</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. U.S.A. retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>S.D.</u>		11. BIRTHPLACE (State or foreign country) <u>M.S.A.</u>	
13. FATHER'S NAME <u>Charles Hale</u>				14. MOTHER'S MAIDEN NAME <u>Lulu Harte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #2 450-26-6958</u>		17. INFORMANT <u>Lt. Col. Leland Hale, 650 Coronado Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Grand death</u> DUE TO (c) <u>infect</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

12757

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth C. Hall</u>		4. DATE OF DEATH <u>Nov. 1 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR <u>40</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
13. BIRTH PLACE (State or foreign country) <u>Atwood, Tenn.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>Robert Yancy Carter</u>		16. MOTHER'S MAIDEN NAME <u>Louisa Harwood</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>NONE</u>	
19. INFORMANT <u>pt's Admission Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 31</u> , 19 <u>59</u> to <u>Nov 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lillian Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>Nov. 1, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Lillian Ziegler M.D.</u>		OLNEY, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u> ADDRESS <u>1300 N. STREET, N.W. - WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>Nov 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

District of Columbia

DECEASED

Washington

Office of the Registrar

For the purpose of this certificate, the name of the deceased is

Robert Lee Carter

born at Baltimore, Maryland, on the 18th day of

November, 1875

and died at Baltimore, Maryland, on the 10th day of

January, 1917

at the age of 41 years, 10 months, and 22 days

caused by

Heart Disease

the result of

long illness

and was buried at

the same place

on the 11th day of

January, 1917

at the age of 41 years, 10 months, and 22 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12758

CERTIFICATE OF DEATH

12725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8505 Hazelwood Drive		d. STREET ADDRESS 8505 Hazelwood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ALICE HALLER		4. DATE OF DEATH Month Day Year Nov. 25 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 3 Days 8	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph Steinhauer		14. MOTHER'S MAIDEN NAME Margaret Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elden D. Haller-son-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acidosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus & dehydration DUE TO (c) coma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic C-V. disease			
19. INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20, 1956 , to 11/25, 1957 , that I last saw the deceased alive on 11/25, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 11/25/57			
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Md	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit 11/25/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery		22d. LOCATION (City, town, or county) (State) Columbus, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE C. L. S. H.	



Item 7 Film G253 12-15-59 et 12759 12726 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 090 1 12759 12726 VS A15 (4) 15M 10/57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville,	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Hamilton Last Hamilton		4. DATE OF DEATH Month Nov. Day 21 Year 1959	
5. SEX male	6. COLOR OR RACE O	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Hamilton		14. MOTHER'S MAIDEN NAME Mary White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dickerson, M. R. F. D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Infection; Anuria Indwelling Catheter 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemiplegia; Paraphymosis; DUE TO (c) Hypertensive C.R. Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 18, 1959 to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 18, 1959 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 DATE SIGNED 11/23/59			
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Webster Sewell	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion,		22d. LOCATION (City, town, or county) Barnesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Suonden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR NOV 30 '59	
		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

CERTIFICATE OF DEATH

See Instructions

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

CHARACTER OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12727

Reg. Dist. No.

12760

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Chevy Chase		d. STREET ADDRESS 116 Grafton Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) National Institutes of Health			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian R. Hancock			4. DATE OF DEATH Month November Day 30 Year 1959			
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH June 18, 1886		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired office worker			10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Carlin Stan			
14. MOTHER'S MAIDEN NAME Annie Roberts			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None			17. INFORMANT Address Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall from bed DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 19 days 11/11/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Leukemia					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed in hospital				
20c. TIME OF INJURY Month, Day, Year 1:30 Hour a. m. 11 11 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		
20f. (City or town) Bethesda		(County) Montg.		(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Frank J. Broschart</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 11/30/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		
22d. LOCATION (City, town, or county) Washington, D. C.		(State) 		24a. REC'D BY REGISTRAR DEC 2 '59		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland			
24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hume</i>			DATE DEC 2 '59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SOURCE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1d, Film G253 12/4/59 iwr

CERTIFICATE OF DEATH

Reg. Dist. No.

12728

12761

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10605 Dunkirk Drive <i>Private home of daughter</i>		d. STREET ADDRESS 109 Rigdon Road	
3. NAME OF DECEASED (Type or print) SUSANNA SCOTT Hardy		4. DATE OF DEATH Month Nov Day 29 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/82
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. SURRATT		14. MOTHER'S MAIDEN NAME MARY E. HUNTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. John H. Hardy, 7200 Hilton Ave.		Address Takoma Park, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleurisy + pneumonia, rt. lung		INTERVAL BETWEEN ONSET AND DEATH 10 min. 15 yrs. (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 27 , 19 59 , to Nov. 29 , 19 59 , that I last saw the deceased alive on Nov. 27 , 19 59 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip H. Varner		ADDRESS (Street, city or town, state) 10,620 Ida, Ave.	
PHYSICIAN'S NAME (Type) PHILIP H. VARNER		DATE SIGNED 11-29-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/59	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. <i>Raymond A. Liska</i>		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. COUNTY Baltimore		8. CITY OR TOWN Baltimore		9. STREET 1000 North Avenue		10. APARTMENT OR BOX None		11. ZIP CODE 21201		12. MANNER OF DEATH Suicide	
13. OCCUPATION None		14. EDUCATION High School		15. MARITAL STATUS Single		16. RELIGION None		17. CAUSE OF DEATH Gunshot wound		18. EFFECT OF ALCOHOL OR DRUGS None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF WITNESS None		21. SIGNATURE OF PHYSICIAN None		22. SIGNATURE OF MORTUARY None		23. SIGNATURE OF REGISTRAR None		24. SIGNATURE OF CLERK None	
25. DATE OF BIRTH None		26. DATE OF DEATH None		27. DATE OF BURIAL None		28. DATE OF CREMATION None		29. DATE OF INTERMENT None		30. DATE OF EXHUMATION None	

12678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b since Apr. 1955			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVENTIDE NURSING HOME, 700 HUDSON AVE.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Juliet A Harper				4. DATE OF DEATH NOVEMBER 5 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/7/73	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Bureau of Printing & Engraving)				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George A. Harper				14. MOTHER'S MAIDEN NAME Mary Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Walter D. Gilson, 11,605 Maple View Dr. Silver Spring, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Semility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1955 to Nov 5, 1959 , that I last saw the deceased alive on Nov. 3, 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard A. Fitzgerald				ADDRESS (Street, city or town, state) 217 University Blvd E.			
DATE SIGNED 11-5-59							
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/9/59		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House							

CERTIFICATE OF EVIDENCE

12345

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

12345

WITNESSES

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WITNESSES

WITNESSES

WITNESSES

WITNESSES

CERTIFICATE OF DEATH

Reg. Dist. No.

12730

12762

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>R</u> Last <u>Harter</u>		4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-27-91</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Ross</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Seacrest</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>4953 Bondjini NW</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection small bowel & ascending colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
570.2 DUE TO <u>Meenteric venous thrombosis</u>		36 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u></u>	
(c) <u></u>		(d) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-Sclerotic Heart Disease, 10 years (+)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Nov. 22</u> , 19 <u>59</u> , to <u>Nov. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>59</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Karl Dortzbach</u> M.D. <u>5123 Tilden N. W.</u>		DATE SIGNED <u>11/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Karl Dortzbach, M.D.</u>		Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1330

CERTIFICATE OF DEATH

1330

1

1

Blank certificate form with faint lines and text.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12763

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Rossville Last HECKEY				4. DATE OF DEATH Month November Day 4 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-04	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Colorado	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Rossville Heckey				14. MOTHER'S MAIDEN NAME Elizabeth Marah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. INFORMANT (Wife) Casta Heckey Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus & Metastases 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9 September , 19 59 , to 4 November , 19 59 , that I lost saw the deceased alive on 4 November , 19 59 , and that death occurred at 1:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 11-5-59 DATE SIGNED ACTUAL SIGNATURE David Osborne M.D. U.S. Naval Hospital, Bethesda Md. 11-5-59 PHYSICIAN'S NAME (Type) D.P. OSBORNE CAPT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Thompson				ADDRESS 557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Knead			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/10/52

Montgomery

11/10/52

Bellevue (Hwy.)

11/10/52 N.Y. San Diego

U.S. Naval Hospital, Bethesda Md.

11/10/52

Montgomery

Alford

11/10/52

White

White

11/10/52

U.S. Government

U.S. Navy

11/10/52

Bellevue Hospital

11/10/52 (Hwy.) San Diego

11/10/52

11/10/52

11/10/52

11/10/52

11/10/52

11/10/52

11/10/52 U.S. Naval Hospital, Bethesda Md.

11/10/52 U.S. Naval Hospital, Bethesda Md.

11/10/52 U.S. Naval Hospital, Bethesda Md.

11/10/52

11/10/52

11/10/52

11/10/52

11/10/52 U.S. Naval Hospital, Bethesda Md.

12764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Fairland Nursing Home, Fairland Road				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2			
f. STREET ADDRESS 4821 Rhode Island Ave.,				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCES Middle HAYNES Last ANDREWS HERBERT				4. DATE OF DEATH Month November Day 28th, Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2nd, 1868	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Andrews				14. MOTHER'S MAIDEN NAME (Unknown) Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Elnora V. Day, 4821 Rhode Island Ave., Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis - right 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 hrs 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7 - 1956 to 11-28, 1959 , that I last saw the deceased alive on 11-28, 1959 , and that death occurred at 11:30P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6110--43rd Avenue, Hyattsville, Md. DATE SIGNED Nov. 30th, 1959							
ACTUAL SIGNATURE John P. Clum M.D.				PHYSICIAN'S NAME (Type) John P. Clum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/1959		22c. NAME OF CEMETERY OR CREMATORY Mount View Mausoleum		22d. LOCATION (City, town, or county) (State) Pasadena, California	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12765

CERTIFICATE OF DEATH

12733

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea-Woodland Nursing Home				d. STREET ADDRESS 1203 E. Hamilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle MARIE Last HICKMAN				4. DATE OF DEATH Month NOV. Day 26 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/76	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DAVIS				14. MOTHER'S MAIDEN NAME ROSE BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT		Address Mrs. Ludwell F. Catlett, 9307 Walden Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure 6 mos							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension 10 yrs							
(c) Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1958 , 19___, to Nov. 26 , 19 59 , that I last saw the deceased alive on Nov. 24 , 19 59 , and that death occurred at ___ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.W. Smith				ADDRESS (Street, city or town, state) 13018 GEORGIA AVE DATE SIGNED 11/26/59			
PHYSICIAN'S NAME (Type) A.W. SMITH				SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 1 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

12765

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

DECEASED

DECEASED

Copy of death certificate

Signature

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

CERTIFICATE OF DEATH

12734

12766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>47</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic City</u> <u>67x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>914 Baltic Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Farley</u> Last <u>Hilliard</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 3, 1957</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herbert L. Hilliard</u>				14. MOTHER'S MAIDEN NAME <u>Justine Wilkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial or Gastro-intestinal Hemorrhage.</u> <u>193.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Neuroblastoma with Metastases</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 8, 1959</u> , to <u>November 18, 1959</u> , that I last saw the deceased alive on <u>November 18, 1959</u> , and that death occurred at <u>6:01 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>11-19-59</u> DATE SIGNED ACTUAL SIGNATURE <u>Harold J. Fallon</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>HAROLD J. FALLON, M.D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>11-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Mount, N.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frazier's Funeral Home, Inc. 389-R.D. Ave. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12767

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 2300 Conn. Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VICTOR Middle (n) Last HOLDEN				4. DATE OF DEATH Month November Day 27 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-99	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James F. HOLDEN				14. MOTHER'S MAIDEN NAME Charlotte ELSWORTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 106-07-2794		INFORMANT (Wife) Myra Holden Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 14 November , 19 59 , to 27 November , 19 59 , that I last saw the deceased alive on 27 November , 19 59 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>[Signature]</i> M.D. U.S. Naval Hospital, Bethesda Md. 11-28-59 PHYSICIAN'S NAME (Type) J?L. BEEBY LT MC USN U.S. Naval Hospital, NNM, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-30-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George County	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR DATE DEC 2 '59		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of death. Page 4 of death. Page 4 of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12783

Washington

Bartholomew (Barth)

12 days

Washington

2300 Ocean Ave.

U.S. Naval Hospital, Bethesda Md.

VICTOR

(a)

HOLLEN

November

WIFE

Wife

2-24-33

60

Foreign Service Officer U.S. Government

Oklahoma

U.S.

James F. HOLLAN

CHARLOTTE HOLLAN

100-C-274 (Wife) John Hollan

1

Oklahoma, Tulsa

Wife

27 November 1933

27 November

28

2:30P

U.S. Naval Hospital, Bethesda Md. 11-25-33

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Prison Guard's Office

Decorative Office

Decorative

U.S. Naval Hospital, Bethesda Md.

12768

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edna A. Holloran First Middle Last				4. DATE OF DEATH Nov. 8 19 59 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4 1934	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Conrad Eber				14. MOTHER'S MAIDEN NAME Sophia Aigler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Yes			
17. INFORMANT Daughter Address Md.				18. MOTHER'S MAIDEN NAME Margaret A. Holloran			
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				20. SOCIAL SECURITY NO. Yes			
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) CORONARY ARTERIO SCLEROSIS				INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 2 HOURS 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE; CORONARY 1958				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March , 19 55 to Nov. 8 , 19 59 , that I last saw the deceased alive on Nov. 8 , 19 59 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph D. Connor M.D.				ADDRESS (Street, city or town, state) 9420 OLD GEORGETOWN RD 8 Nov. 59.			
PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR				BETHESDA MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/10/59			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR NOV 13 '59 DATE			
24b. REGISTRAR'S SIGNATURE James S. Kneale							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. 2. 1. 2

Integrating the two sides of (1) yields

NAME _____

2173

62

24

13. 4. 008

5

Page 3 of 3

(Delete) 200.

Ref: 32002

CONFIDENTIAL

207

PROF. A. J. J. VAN DER WOUDE

CERTIFICATE OF DEATH

Reg. Dist. No.

12769

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o-STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanatorium Hospital</u>				d. STREET ADDRESS <u>1210 E Capital St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Isabel</u> First Middle Last				4. DATE OF DEATH <u>November 3</u> 19 <u>59</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 7 - 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Arizona</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>RESMOR SANATORIUM RECORDS</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO (c) <u>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>3-4 yrs</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 2nd</u> 19 <u>58</u> , to <u>present</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/31</u> 19 <u>59</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savanese, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4800 BATTERY LANE</u> DATE SIGNED <u>11/5/59</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVANESE, JR.</u>				<u>BETHESDA, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-6-59</u>		<u>McAlister Cemetery</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> 3821-14th St. NW Wash. D.C.				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH FBI Office, Memphis, Tenn.		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)		19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JUDGE (None)	
21. SIGNATURE OF REGISTRAR (None)		22. SIGNATURE OF CLERK (None)		23. SIGNATURE OF ASSISTANT CLERK (None)		24. SIGNATURE OF CHIEF CLERK (None)		25. SIGNATURE OF DEPUTY CLERK (None)	

1

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar and the other copy is to be forwarded to the office of the State Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9, Film G-252 12/11/59.cac.

Reg. Dist. No.

12738

12770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>and DC</u> b. COUNTY <u>man</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3		d. STREET ADDRESS <u>1329 Fort Stevens Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Argyle Country Club</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Thomas</u> Last <u>Houston</u>				4. DATE OF DEATH Month <u>nov</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1905</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shorter Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Huston</u>				14. MOTHER'S MAIDEN NAME <u>Martha Lyons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW # 2</u>		17. INFORMANT <u>Dorothy Houston</u>		Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed on golf course while playing golf</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

127771

CERTIFICATE OF DEATH

12739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lois Middle Howley Last Howley		4. DATE OF DEATH Month November Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1887
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR 2 Months 16 Days 16 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Greschner		14. MOTHER'S MAIDEN NAME Laura Bell Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 064-20-0252	
17. INFORMANT Theresa Maury-daughter-Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 572.1 IMMEDIATE CAUSE (a) Acute Exhaustion, Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Bleeding diverticulitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Chronic infection, left hip: Old fracture, left hip			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jun , 19 58 , to Nov 17 , 19 59 that I last saw the deceased alive on Nov 15 , 19 59 and that death occurred at 8:40 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 10609 Concord Street Nov 17, 1959	
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. Bur.		22b. DATE THEREOF 11-20-59	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 23 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

STATE OF CALIFORNIA

1937

County of ...

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CERTIFICATE OF DEATH

Reg. Dist. No.

12772

12740

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY The District of Columbia 47x3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4602 4th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle LEE Last HUNT		4. DATE OF DEATH Month November Day 3, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1953
9. AGE (In years lost birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Camden Hunt		14. MOTHER'S MAIDEN NAME Elenore Gandee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and septicemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 days 10 months
MEDICAL CERTIFICATION 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 28, 1959 to November 3, 1959 , that I last saw the deceased alive on November 3, 1959 , and that death occurred at 12:05 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Lawrence A. Gaydos M.D.		DATE SIGNED 11-3-59	
PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 11/4/59	22c. NAME OF CEMETERY OR CREMATORY Wash. Nat. C.	22d. LOCATION (City, town, or county) (State) Ripley, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS Co.		24. REC'D BY REGISTRAR Nov 5 '59	
ADDRESS 1400 Chapin Street		24b. REGISTRAR'S SIGNATURE Arthur E. King	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12732

CERTIFICATE OF DEATH

12732

County of Columbia
The District of Columbia
The Clinical Center, Bethesda, Md., U.S.A.
1952
November 3, 1952
Male
White
Child
None
The Clinical Center, Bethesda, Md., U.S.A.
None
Acute lymphatic leukemia
10 months
10 days

November 3, 1952
October 28, 1952
November 3, 1952
The Clinical Center
National Institutes of Health
Bethesda, Md., U.S.A.
Lawrence A. Gey, M.D.
Renal
11-3-52

CERTIFICATE OF DEATH

Reg. Dist. No.

12741

12773

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arizona b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEFFREY Middle LEE Last HUTCHISON				4. DATE OF DEATH Month November Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1953	
9. AGE (In years lost birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frank Hutchison				14. MOTHER'S MAIDEN NAME Leada Corbin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastrointestinal Hemorrhage DUE TO (c) Acute leukemia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year							
INTERVAL BETWEEN ONSET AND DEATH Hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 13, 1959 , to November 15, 1959 , that I last saw the deceased alive on November 15, 1959 , and that death occurred at 11:15 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE Laurence A. Gaydos M.D.				ADDRESS (Street, city or town, state) The Clinical Center 11-16-59			
PHYSICIAN'S NAME (Type) Laurence A. Gaydos M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Logan National		22d. LOCATION (City, town, or county) (State) Denver Colo.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 CHAMBERS ST. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

130

CERTIFICATE OF DEATH

Reg. Dist. No.

12742

12774

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2111 Forest Glen Road		e. STREET ADDRESS 3800 New Hampshire Ave. f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle A. Last HYAM		4. DATE OF DEATH Month November Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/74
9. AGE (In years lost birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Schnebel	
14. MOTHER'S MAIDEN NAME Emma Piepenbring		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. ADDRESS Mrs. Evelyn Gwynn, 2111 Forest Glen Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency INTERVAL BETWEEN ONSET AND DEATH immediate 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation months (c) Arteriosclerosis indeterm. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 59 to 19 59 , that I last saw the deceased alive on November 17 , 19 59 , and that death occurred at 1:43 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. L. Marston, M.D.			
ACTUAL SIGNATURE E. L. Marston MD		M.D. E. L. Marston, M.D.	
PHYSICIAN'S NAME (Type) 800 Pershing Drive, Silver Spring		November 17, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/19/59	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. RECORDING REGISTRAR DATE NOV 19 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1971

111 West 10th Street

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CERTIFICATE OF DEATH

Reg. Dist. No.

12775

12743

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Rock Creek Hills		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9528 Kensington Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID First M. Middle IACONE Last		4. DATE OF DEATH November 9, 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR 11 Months 25 Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Manager		10b. KIND OF BUSINESS OR INDUSTRY Dry-Cleaning Est.	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Amedeo Constantine Iacone		14. MOTHER'S MAIDEN NAME Mary Grosso	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-03-2811	
17. INFORMANT Wife Address Same as Item #2		18. NAME Ellis H. Iacone	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 16 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 NOV 59 to 9 NOV 59 , that I lost sight of the deceased alive on 9 NOV 59 , and that death occurred at 9:12 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm H Beard		DATE SIGNED 10 NOV 59	
PHYSICIAN'S NAME (Type) WILLIAM H. BEARD		ADDRESS (Street, city or town, state) WM. H. BEARD, M. 2814 CONN. AVE. WASHINGTON 8, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-13-59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR NOV 13 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur E. Harris

CORONER NOTIFIED & WILL APPROVE.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED BY THE U.S. DEPARTMENT OF JUSTICE

1937

CERTIFICATE BY THE U.S. DEPARTMENT OF JUSTICE

RECEIVED BY THE U.S. DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12776

CERTIFICATE OF DEATH

12744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 or 10 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JANE CAROLINE IVERSON		4. DATE OF DEATH Month 11 Day 21 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 11 Days 21 Hours 19 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Holland		14. MOTHER'S MAIDEN NAME Louise Hansmann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. G. P. Iversen, 1208 Geranium St., N.W. Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis and senility DUE TO (c) 4.5 years		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma right breast (Paget's disease)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2, 1955 , to 11-21-1959 that I last saw the deceased alive on 11-20-1959 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason Geiger		DATE SIGNED 11-21-59	
PHYSICIAN'S NAME (Type) JASON GEIGER		ADDRESS (Street, city or town, state) 931 PERSHING DR. SILVER SPRING MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 11/24/59		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORY WHITNEYVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) HAMDEN, CONN.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1975

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12777

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Annadale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS 1202 Bristow Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Vincent Last JENSEN				4. DATE OF DEATH Month November Day 30 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-15-21	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 38		IF UNDER 24 HRS. Hours 38		Min. 38	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jens JENSEN				14. MOTHER'S MAIDEN NAME Caroline GORGESSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. INFORMANT (Wife) Audery H. Jensen Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Failure (c) malignant hypertension Benign Hypertensive Vasc. Disease							INTERVAL BETWEEN ONSET AND DEATH 2 mo 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 13 November, 19 59 , to 30 November, 19 59 , that I lost saw the deceased alive on 30 November, 19 59 , and that death occurred at 10:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-30-59							
ACTUAL SIGNATURE Fred H. O'Connell				M.D. U.S. Naval Hospital, Bethesda Md. 11-30-59			
PHYSICIAN'S NAME (Type) Fred H. O'CONNELL				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home ADDRESS 2847 Wilson Blvd. Arlington, Va.				24a. REC'D BY REGISTRAR DEC 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12778

CERTIFICATE OF DEATH

12746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arizona</u> b. COUNTY <u>Tucson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tucson</u>			
c. LENGTH OF STAY IN 1b <u>223 days</u>				41x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1515 North Columbus Boulevard</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Judith Charlotte Jones</u>				4. DATE OF DEATH Month Day Year <u>November 11 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 20, 1941</u>	
9. AGE (In years lost birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Milton C. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Lorna Hafner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 173x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Choriocarcinoma</u> DUE TO (c) <u>11 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 2, 1959</u> , to <u>November 11, 1959</u> , that I lost sows the deceased olive on <u>November 11, 1959</u> , and that death occurred at <u>3:30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center 11-11-59</u> DATE SIGNED ACTUAL SIGNATURE <u>SAUL GENUTH</u> M.D. <u>National Institutes of Health Bethesda 14, Maryland</u> PHYSICIAN'S NAME (Type) <u>SAUL GENUTH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. Bur.</u>				22b. DATE THEREOF <u>11-12-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Southlawn Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Tuscon, Arizona</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12748

CERTIFICATE OF DEATH

12772

Arizona

Tucson

283 days

Bedford

The Clinical Center, Bedford, N.H.

Johnston, John

September 20, 1911

Bedford

Bedford

Bedford

The Clinical Center, Bedford, N.H.

6 hours

Bedford

Bedford

11 hours

April 2, 1912

November 11, 1912

11-11-12

The Clinical Center

Bedford, N.H.

Bedford, N.H.

Tucson, Arizona

Bedford, N.H.

Robert A. Knapp, Bedford, N.H.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12747

12779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>— —</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Jane</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8-1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Edward Titus</u>				14. MOTHER'S MAIDEN NAME <u>Mary K. McKimney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>William Jones, Poolesville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Acute</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>5 years</u> <u>9 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1949</u> , to <u>1 November, 1959</u> , that I last saw the deceased alive on <u>30 October, 1959</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Gordon M. Smith</u> ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u> DATE SIGNED <u>1 Nov 59</u> PHYSICIAN'S NAME (Type) <u>Gordon M. Smith</u> <u>Barnesville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>				ADDRESS <u>Barnesville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12748

12780

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Cherry Point c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 x-3 d. STREET ADDRESS 511 "B" Enlisted Mens Quarters e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Leroy Last JONES		4. DATE OF DEATH Month November Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-15
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44	11. IF UNDER 24 HRS. Hours 44 Min. 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Horace JONES		14. MOTHER'S MAIDEN NAME Elizabeth KINSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 249 05 2015	
17. INFORMANT (Wife) Vera B. JONES		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Insufficiency 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphosarcoma Reticulum DUE TO (c) Cell type Interval between onset and death 5 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 October , 19 59 , to 23 November , 19 59 , that I last saw the deceased alive on 23 November , 19 59 , and that death occurred at 7:23P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-24-59			
ACTUAL SIGNATURE William B. Baker		M.D. U.S. Naval Hospital, Bethesda Md. 11-24-59	
PHYSICIAN'S NAME (Type) W.P. BAKER LT MC USN		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-27-59	
22c. NAME OF CEMETERY OR CREMATORY Buckhead Church Cemetery		22d. LOCATION (City, town, or county) (State) Bamberg, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE W.W Chambers		24. REC'D BY REGISTRAR NOV 27 '59	
ADDRESS 1400 Chapin Street N.W. Washington D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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U.S. Naval Hospital, Ponce, P.R.

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INDEX

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Labels

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12749

12781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3503 Woodbine St.</u>		d. STREET ADDRESS <u>3503 Woodbine St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RYLAND LEE JOYNER</u> First Middle Last		4. DATE OF DEATH <u>November 28 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Chastine J Joyner</u>		14. MOTHER'S MAIDEN NAME <u>Belle E. ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>578-07-2863</u>	
17. INFORMANT <u>Helena C Joyner</u> Address <u>3503 Woodbine St Chevy Chase Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>356.1 Amyotrophic Lateral Sclerosis</u> DUE TO (b) <u>Interval between onset and death approx 1 1/2 yrs.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u></u> DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 1 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 11-28 1959</u> , 19 <u>58</u> , to <u>November 28 1959</u> , that I last saw the deceased alive on <u>11-28 1959</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley M. Silverberg</u> M.D.		DATE SIGNED <u>11-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Stanley M. Silverberg, M.D.</u>		3131-16th St., N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Severs Sons Co</u> ADDRESS <u>3605-14 St NW Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

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12782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. LENGTH OF STAY IN lb 2½ years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fred First Middle Last		4. DATE OF DEATH November 2 Month Day Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR 5 Months 4 Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Eng.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Kaulback		14. MOTHER'S MAIDEN NAME Mary Loring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. James Osborne - Daughter - Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH seconds unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19, 1957 , to November 2, 1957 , that I last saw the deceased alive on October 20 , 19 59 , and that death occurred at 11 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring, Md DATE SIGNED Nov 5 '59			
ACTUAL SIGNATURE Aaron H. Traum		M.D. 8237 Georgia Ave Silver Spring, Md	
PHYSICIAN'S NAME (Type) Aaron H. Traum		8237 Georgia Ave. Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-3-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 5 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur E. Trause	

1

3

090

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAA SYNDICATE, INC. 10000 N. CENTRAL EXP. HWY. - SUITE 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12751

12783

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>13 mo.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10402 Georgia Ave</u>			d. STREET ADDRESS <u>10402 Georgia Ave</u>		
3. NAME OF DECEASED (Type or print) <u>MATILDA F.A. KENDRICK</u>			4. DATE OF DEATH <u>Nov 25 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 1868</u>		9. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>John George Killian</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Flack</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>598-50-3044</u>	17. INFORMANT <u>Mrs. Katherine K Sinclair, same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arricular fibrillation</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Nov 25</u> , 1959, that I last saw the deceased alive on <u>Nov 25</u> , 1959, and that death occurred at <u>931A M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John Lawrence Avery</u>		M.D. <u>10110 Georgia Ave</u>		DATE SIGNED <u>Nov 25-59</u>	
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>		<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
				22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jukes</u>		ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12752

12784

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1108 "I" Street S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Anthony Last KEYS		4. DATE OF DEATH Month November Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-59
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lawrence KEYS		14. MOTHER'S MAIDEN NAME Alyce Ensonia DEWITT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Official Hospital Records)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tricuspid Atresia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 November , 19 59 , to 24 November , 19 59 , that I last saw the deceased alive on 24 November , 19 59 , and that death occurred at 2:35A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-24-59 ACTUAL SIGNATURE Fred W Grello M.D. PHYSICIAN'S NAME (Type) F.W. GRELO LT MC USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. BACON ADDRESS 1722 7th Street N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Harris			

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 100. James M. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12753

Reg. Dist. No.

12699

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 26	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2006 Rockland Avenue			d. STREET ADDRESS 2006 Rockland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) WARREN First PATRICK Middle KILEY Last			4. DATE OF DEATH Month November 22, Day 19 Year 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/11		9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR 0 Months 4 Days IF UNDER 24 HRS. 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Scientist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME John Kiley			14. MOTHER'S MAIDEN NAME Gertrude Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-3578		17. INFORMANT Address Mrs Eleanor H. Kiley- Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) History of previous heart disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11-23-59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-25-59	22c. NAME OF CEMETERY OR CREMATORY Mt. Hope		22d. LOCATION (City, town, or county) (State) Village Green, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 1331 E. Montgomery Ave, Rockville, Md.		24a. REC'D BY REGISTRAR NOV 24 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2000

NAME OF DECEASED
JAMES M. BROWN

DATE OF DEATH
JAN 10 1900

PLACE OF DEATH
HOME

AGE
45

SEX
MALE

RACE
WHITE

EDUCATION
HIGH SCHOOL

OCCUPATION
FARMER

RELIGION
METHODIST

PREVIOUS ILLNESS
NONE

CAUSE OF DEATH
HEART DISEASE

DETAILS OF CASE
The deceased was found dead in his bed, having been ill for several days with a cold and cough. He was taken to the hospital where he died.

TESTIMONY OF MEDICAL EXAMINER
I, JAMES M. BROWN, a duly licensed Medical Examiner of the State of Maryland, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

SIGNATURE OF MEDICAL EXAMINER
JAMES M. BROWN

DATE
JAN 10 1900

PLACE
BALTIMORE

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12754

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 23 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11430 Maple View Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle HEINRICH Last KUNDT		4. DATE OF DEATH Month NOV. Day 24 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/84
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Haines Lithograph	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST KUNDT		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-12-7635	
17. INFORMANT Mrs. Erna M. Kundt, 11430 Maple View Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases to Livers DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/20/59 19 to 11/24/59 19 that I last saw the deceased alive on 11/24/59 19 and that death occurred at 8 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 11/24/59			
ACTUAL SIGNATURE John J. Curry		PHYSICIAN'S NAME (Type) JOHN J. CURRY	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1-10-1880		BALTIMORE		MD		MD		USA	
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
LABORER		MARRIED		HIGH SCHOOL		METHODIST		WHITE		WHITE		5' 8"		160	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
1-15-1925		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FAMILY	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

CERTIFICATE OF DEATH

12755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>56 Silver Spring</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>18419 Queen Annes Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Ford</u> Last <u>Lantz</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	11. IF UNDER 24 HRS. Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Laundry Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Washington San. + Hosp. Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.0</u> DUE TO <u>intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Duodenal peptic ulcer</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>10-20</u> , 19 <u>59</u> , to <u>11-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-6</u> , 19 <u>59</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley M. Silverberg</u>		ADDRESS (Street, city or town, state) <u>3131 16th St. N.W. Wash, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY M. SILVERBERG, M.D.</u>		DATE SIGNED <u>11/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Nov 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Md</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wick Hunt</u>		ADDRESS <u>5732 La Gr</u>	
24a. REC'D BY REGISTRAR <u>Nov 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OF THE ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12786

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS Brighton Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Belle		First Heath		Last LEE		4. DATE OF DEATH Month November Day 21 Year 19 59		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-27-86		
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James E. HEATH				14. MOTHER'S MAIDEN NAME Virginia UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NO		INFORMANT (Husband) Sydney S. Lee		Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 17 November, 1959 , to 21 November, 1959 , that I last saw the deceased alive on 21 November, 1959 , and that death occurred at 5:45 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE * Brun L. Royal Lt (MC) USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-22-59						
PHYSICIAN'S NAME (Type) P. L. ROYAL LT MC USN		U.S. Naval Hospital, Bethesda Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers & Sons				ADDRESS 1756 Penn. Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR NOV 25 '59		
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas				

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

12680

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SAN. & Hospital</u>		d. STREET ADDRESS <u>10805 E. Nolcrest Dr</u>	
3. NAME OF DECEASED (Type or print) <u>LEIBOWITZ, Mr. REUBEN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-11</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATENT EXAMINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEIBOWITZ, Mr. William</u>		14. MOTHER'S MAIDEN NAME <u>PEARLMAN, I DA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>LEIBOWITZ, Mrs. Betty</u>		Address <u>10805 E. Nolcrest Dr, S.S.M.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u> DUE TO <u>YEARS</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>MOMENTS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>PRESENT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-2-1959</u> , and that death occurred at <u>8:11 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abraham W. Danish</u> M.D.		ADDRESS (Street, city or town, state) <u>927 PERSHING DR SILVER SPRING, MD.</u>	
DATE SIGNED <u>11-4-59</u>			
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/6/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-2nd Ave</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert E. Rouse</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3880

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		PLACE OF DEATH _____		COUNTY _____	
TIME OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		SEX AT BIRTH _____	
OCCUPATION _____		EDUCATION _____		MARITAL STATUS _____	
PREVIOUS ILLNESS _____		PRESENT ILLNESS _____		MEDICAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		COUNTY HEALTH OFFICER'S SIGNATURE _____		DEATH CERTIFICATE NUMBER _____	
DATE OF SIGNATURE _____		PLACE OF SIGNATURE _____		COUNTY OF SIGNATURE _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2307 West View Dr</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>2307 West View Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Lerario</u> Last <u></u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1959</u>												
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>2-9-1887</u>		9. AGE (In years last birthday) <u>72</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>															
13. FATHER'S NAME <u>Peter Lerario</u>			14. MOTHER'S MAIDEN NAME <u>Mary Jane De Marinis</u>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Peter Lerario (son)</u> Address <u>2711 Newton St Silver Spring Md</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cormary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cormary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cormary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>													
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>											
20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>												
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Nov 16 - 1959</u>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>											
22d. LOCATION (City, town, or county) <u>Prince Georges Co Maryland</u>		(State) <u></u>													
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Huntemann & son</u>			ADDRESS <u>5732 Georgia Ave N. W.</u>												
24a. REC'D BY REGISTRAR <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trana</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item

12/3/59 lwk

12788

CERTIFICATE OF DEATH

Reg. Dist. No.

12759

1. PLACE OF DEATH a. COUNTY <u>MONT. GO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Levy</u> Last <u>Levy</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/89</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Bernton</u>				14. MOTHER'S MAIDEN NAME <u>Rose Davidson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma of rectum</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meta. Foci in liver, lungs, lymph nodes, bone marrow</u> DUE TO (c) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>59</u> to <u>11-25</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11-23</u> , 19 <u>59</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u>				ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				DATE SIGNED <u>11-25-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wakefield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middlesex Co. Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pomphrey</u>				ADDRESS <u>7557 Wisc. Ave. Balt.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ORIGINAL FILED

13328

CERTIFICATE OF DEATH

MADE AT THE HEALTH DEPARTMENT

1924

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 15 1879*
5. Place of birth: *New York City*
6. Usual residence: *123 Main St, New York City*
7. Date of death: *Dec 10 1924*
8. Place of death: *Home*
9. Cause of death: *Heart Disease*
10. Signature of physician: *J. Smith*
11. Signature of registrar: *A. Jones*
12. Signature of informant: *M. Doe*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12760

12681

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takome Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		d. STREET ADDRESS 813 Ingraham St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennings L. Lewis		4. DATE OF DEATH Month Day Year November 30 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/1885
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet maker, white House		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Lewis		14. MOTHER'S MAIDEN NAME Matilda Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 587-52-2353	
INFORMANT Richard L. Stakes		Address Bethesda, Md. 5505 Glenwood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 12 months 15 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/17/59 , to 11/30 , 19 59 , that I last saw the deceased alive on 11/27/59 , 19 59 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Umhau		ADDRESS (Street, city or town, state) 8805 Conn. Ave	
PHYSICIAN'S NAME (Type) JOHN B. UMHAU		DATE SIGNED 11/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59	
22c. NAME OF CEMETERY OR CREMATORY Bethany Baptist Church		22d. LOCATION (City, town, or county) (State) Callao, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.		24a. REC'D BY REGISTRAR DEC 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13281

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613 Indiana St. N.W.

Washington, D.C.

20 November 30

Lewis

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12/17/1887

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Martha Jones

David Lewis

Washington, D.C.

287-52-2252 Richard E. Blaine, 1902

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUATTSVILLE</u> <u>1615-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN ^{2d} Hospital</u>				d. STREET ADDRESS <u>7502 Wells Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>JAY</u> Last <u>LEWIS</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JUNE 25, 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>POHAVA UKRAINE</u>			
13. FATHER'S NAME <u>Joseph Rubin</u>				14. MOTHER'S MAIDEN NAME <u>MIRIAM SKLORSKY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>579-01-7937</u>		17. INFORMANT <u>DORALEE LEWIS</u> <u>7502 Wells Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-27-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				_____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM. ARLINGTON - VA.</u>			
22d. LOCATION (City, town, or county) _____		(State) _____		_____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY + SONS - 3501 - 14th St NW</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>			
ADDRESS _____				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print Name and Surname) JOHN J. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH 1945	
6. PLACE OF DEATH (City, County, State) Baltimore, Maryland		7. OCCUPATION Engineer		8. CAUSE OF DEATH (Immediate) Myocardial Infarction		9. MANNER OF DEATH (Legal) Natural		10. SIGNATURE OF EXAMINER [Signature]	
11. HISTORY OF ILLNESS (Describe symptoms, duration, treatment) Onset of chest pain and shortness of breath on 10/15/45. Pain radiated to left arm. No relief with rest or nitroglycerin. Died 10/16/45.		12. PREVIOUS ILLNESS (List chronic conditions) None		13. MEDICATION (List drugs and doses) None		14. POST-MORTEM (List findings) None		15. SIGNATURE OF WITNESS [Signature]	
16. SIGNATURE OF NEXT OF KIN [Signature]		17. SIGNATURE OF CLERK [Signature]		18. SIGNATURE OF JURY [Signature]		19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JURY [Signature]	



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12789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4610 Chase Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORA Middle HUNTER Last LOGAN				4. DATE OF DEATH Month Nov. Day 9 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1868	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 7 Days 28	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME George Gartrell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address William Logan-son-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Coronary + Cerebral Arteriosclerosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 70 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 4/1955 , 19 55 to 11/9 , 19 59 , that I last saw the deceased alive on 11/9 , 19 59 , and that death occurred at 9:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Seymour Greenbaum				ADDRESS (Street, city or town, state) DATE SIGNED 11/9/59 9300 Ewing Drive, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Seymour Greenbaum				9300 Ewing Drive, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13788

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12763

12790

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 MANCHESTER PLACE APT. 101				d. STREET ADDRESS 6 MANCHESTER PLACE APT. 101	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANNA (NMI) LORENZEN			4. DATE OF DEATH NOV. 8 1959		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH FEB. 11, 1884		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN SCHIDTLER			
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address WM. F. LORENZEN, 6 MANCHESTER PLACE, SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) arterio-sclerotic vascular heart disease DUE TO 2 yrs (c) 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-9-59	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/12/59		22c. NAME OF CEMETERY OR CREMATORY SORDIS CHAPEL CEMETERY	
22d. LOCATION (City, town, or county) (State) ST. MICHAELS, MARYLAND		23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Ziska			
24a. REC'D BY REGISTRAR NOV 13 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,4 FilmG252 11-24-59 et

CERTIFICATE OF DEATH

12764

Reg. Dist. No.

12791

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b Life time		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Springs, Md.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William		Middle Fenmore		Last Lynn		4. DATE OF DEATH Month Nov.		Day 14		Year 1959		5. SEX Male		6. COLOR OR RACE Col	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) April 4 1904		10. IF UNDER 1 YEAR Months 11		Days 14		Hours 11		Mins. 59		11. BIRTHPLACE (State or foreign country) Manhasset	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Lynn		14. MOTHER'S MAIDEN NAME Mary Carter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 330X		17. INFORMANT Nellie L. Bishop, Sandy Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Cerebral Artery DUE TO Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Sclerosis DUE TO Vascular Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 330X		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 5, 1958 to Nov. 7, 1959 , that I last saw the deceased alive on Nov. 7, 1959 and that death occurred at 4:10 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Webster Sewell		M.D. Rt. Silver Spring		ADDRESS (Street, city or town, state) Norbeck		DATE SIGNED 11-16-59		PHYSICIAN'S NAME (Type) WEBSTER SEWELL		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/59		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery	
22d. LOCATION (City, town, or county) Sandy Springs		(State) Md		23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden - Rockville, Md		ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR NOV 19 59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans		24c. DATE NOV 19 59		24d. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF THE

18301

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12765

Reg. Dist. No.

12683

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>57 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp</u>				d. STREET ADDRESS <u>709 FORSTON DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>Mary</u> Last <u>McIntosh</u>				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1922</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Joseph Foley</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE MCCANN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive subarachnoid hemorrhage</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusions and lacerations</u> DUE TO (c) <u>A fall down a flight of stairs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days plus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>11-18</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Takoma Park, Monty, Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 25 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltavell</u>				ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12766

Reg. Dist. No.

12684

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615-2</u> d. STREET ADDRESS <u>8230-14th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Clifton</u> Middle <u>Walter</u> Last <u>Malcolm</u>		4. DATE OF DEATH Month <u>9-11</u> Day <u>18</u> Year <u>1959</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-11</u>		9. AGE (In years last birthday) <u>48</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Walter A. Malcolm</u>						14. MOTHER'S MAIDEN NAME <u>Permelia Pope</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1944-1946</u>				16. SOCIAL SECURITY NO. <u>VI4-07-6654</u>				17. INFORMANT <u>Mrs Lauretta Malcolm - wife</u> Address													
18. CAUSE OF DEATH [Enter only one cause or the order (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>															
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>															
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>11-5-59</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>11-8-1959</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>			22d. LOCATION (City, town, or county) <u>Maconfield, W.D.</u> (State)												
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Right Cumberland</u> ADDRESS						24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>												
DATE <u>NOV 9 '59</u>																					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12684

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY OR TOWNSHIP [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
PRESENT ILLNESS [Illegible]		POST-MORTEM EXAMINATION [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	

NOT REPRODUCIBLE IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE MARYLAND STATE DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>738 Longfellow N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Martin</u> Last <u>West</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BENTON BORDEN WEST</u>	
14. MOTHER'S MAIDEN NAME <u>REBECCA WEST</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Nursing Home Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>433.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post operative strangulated hernia 1 mo ago</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-3-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14 H. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. 12768

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>	c. LENGTH OF STAY IN 1b <i>2mo</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Nursing Home</i>		d. STREET ADDRESS <i>12422 Littleton St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Mo</i> Last <i>Mayerson</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/5-1892</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired office clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Phila Pa</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Louis Mayerson</i>	
14. MOTHER'S MAIDEN NAME <i>Dina Frommer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>145-07-9278</i>		17. INFORMANT <i>Victoria Mayerson</i> Address <i>wife 12422 Littleton St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Respiratory depression</i> DUE TO (b) <i>Cerebral vascular accident</i> DUE TO (c) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>weeks</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Parkinsonism</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 1959</i> to <i>Nov 2, 1959</i> , that I last saw the deceased alive on <i>Oct 12, 1959</i> and that death occurred at <i>6:00 PM</i> , from the causes and on the date stated above.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/3/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Not New York</i>
22d. LOCATION (City, town, or county) (State) <i>Falls Church, Va</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Washington</i> ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>NOV 3 '59</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OF THE DEPARTMENT OF HEALTH: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12769

12794

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>8 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WHEATON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>112128 BLUETHILL ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH Edward McCauley</u>				4. DATE OF DEATH Month Day Year <u>11 4 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carder -</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William McCauley</u>				14. MOTHER'S MAIDEN NAME <u>Anna Badjorn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Yes</u>		INFORMANT <u>X Mary E. Miller</u>		Address <u>daughter 12128 Bluethill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock & pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>ASCVD</u> DUE TO (c) <u>with Calcific aortic stenosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 gm.</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>4 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Nov</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace W. Bernton</u>		DATE SIGNED <u>11-4-59</u>		ADDRESS (Street, city or town, state) <u>10511 Summit Ave. Kensington, Maryland</u>		DATE SIGNED <u>11-4-59</u>	
PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kious</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

074

2

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12795

CERTIFICATE OF DEATH

Reg. Dist. No.

12770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>6607 Brookville Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>McDonald</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1880</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Ellen McDonald Keohane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Julia A. McDonald</u>		Address <u>6607 Brookeville Road, Chevy Chase, 15, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 332x DUE TO <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis</u> (c) <u>Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 21, 19 59</u> to <u>Nov 1, 19 59</u> that I last saw the deceased alive on <u>Nov. 14, 19 59</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>8106 Maple Ridge Rd Bethesda, Md</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sanders</u> ADDRESS <u>1756 P. Ave N.W. R.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



Handwritten signature

Handwritten signature

12796

CERTIFICATE OF DEATH

12771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>92 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1506 52nd Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charmaine</u> Middle <u>Collen</u> Last <u>McFadden</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>19 59</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15, 1954</u>		9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>59</u>	IF UNDER 24 HRS. Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child (None)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James McFadden</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEGENERATIVE CENTRAL NERVOUS</u> <u>355X</u> DUE TO <u>SYSTEM DISEASE - TYPE UNDETERMINED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 14, 1959</u> , to <u>November 14, 1959</u> , that I last saw the deceased alive on <u>November 14, 1959</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11-14-59</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>F. L. Merritt</u>		M.D. <u>The Clinical Center</u>					
PHYSICIAN'S NAME (Type) <u>F. L. Merritt, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall's Funeral Home, Inc.</u> <u>Mt. Rainier, Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1278

JOHN W. HILL

25 years

Married

1500 10th Avenue

the 11th day of January, 1900, at St. Louis, Mo.

Heart Disease

Coronary

Arteriosclerosis

January 15, 1900

Female

Wife of John W. Hill

Age

Child (born)

Before death

After death

The medical history

The clinical history, before and

After

DEGENERATIVE CEREBRAL DISEASE

SYSTEM DISEASE - TYPE UNDETERMINED

January 15, 1900

St. Louis

25

12-15-00

The Clinical History

Medical History of case

Before death

After death

John W. Hill, 25 years old, married, died of

Heart Disease, January 15, 1900, at St. Louis, Mo.

CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 104 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills 16X-2 d. STREET ADDRESS 1506 52nd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawton Middle Morgan Last McFadden			4. DATE OF DEATH Month November Day 26 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1956		9. AGE (In years last birthday) 3 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas			
13. FATHER'S NAME James McFadden			14. MOTHER'S MAIDEN NAME Dolores Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spinocerebellar degeneration DUE TO pyelonephritis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute pyelonephritis, renal abscesses DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 years unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 14, 1959 , to November 26 1959 , that I last saw the deceased alive on November 26, 1959 , and that death occurred at 3:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Unit of Abraham M.D. The Clinical Center DATE SIGNED National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Uristof Abraham		PHYSICIAN'S NAME (Type) Uristof Abraham M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill			
22d. LOCATION (City, town, or county) (State) Suitland, Md		23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc. ADDRESS Mt. Rainier, Md.					
24. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE Carling S. King					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

DEATH
CERTIFICATE
BOND

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Date of registration: _____</p>	
<p>11. Registrar's office: _____</p>	
<p>12. Remarks: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12798

CERTIFICATE OF DEATH

12773

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2520 PLYERS MILL ROAD				d. STREET ADDRESS 1 2520 PLYERS MILL ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CHARLES Middle FREDERICK Last MEYERS, SR.		4. DATE OF DEATH		Month NOV. Day 18 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/90		9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Tire recapping		10b. KIND OF BUSINESS OR INDUSTRY Leith Bros.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES FREDERICK MEYERS				14. MOTHER'S MAIDEN NAME DORA M. LIPPOLD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-09-3182		INFORMANT Mrs. Mabel L. Meyers, 2520 Plyers Mill Road		Address Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1959 to Nov 18, 1959 , that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 7:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W F Greaney		M.D. 7542		ADDRESS (Street, city or town, state) 12th St NW Wash DC		DATE SIGNED Nov 18/59	
PHYSICIAN'S NAME (Type) WM F GREANEY M.D.		7542		12th St NW WASH D.C.		Nov 18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/21/59		22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 20 1959		24b. REGISTRAR'S SIGNATURE Colin S. K...	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9854

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12774

12799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. LENGTH OF STAY IN 1b <u>77 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Mae</u> Last <u>Miles</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1882</u>
9. AGE (In years lost birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home work</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kent King</u>		14. MOTHER'S M maiden NAME <u>Emma Bowman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Howard M. Miles, Jr., Gaithersburg, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, mild</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>11/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>59</u> , and that death occurred at <u>10:25 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. F. Meadors</u>		ADDRESS (Street, city or town, state) <u>MAIN STREET</u> DATE SIGNED <u>11/11/59</u>	
PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>		<u>DAMASCUS, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11.12.59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Arthur</u>		ADDRESS <u>Gaithersburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

0975

1998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12775

Reg. Dist. No.

12800

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>157</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4948 Battery Lane</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4948 Battery Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>H.</u> Last <u>Miller</u> 4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1957</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-21-83</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> 13. FATHER'S NAME <u>Wm Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>F.C.C</u> 14. MOTHER'S MAIDEN NAME <u>Currie Petri</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>275-01-1065</u>		17. INFORMANT <u>Nellie T. Miller-wife-same as 2d</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-13-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Coxsackie, New York</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knecht</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MD 10-100 (Rev. 1-78)
MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. DATE OF BIRTH [Illegible]		4. PLACE OF BIRTH [Illegible]	
5. RACE [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. SOCIAL SECURITY NUMBER [Illegible]	
9. DATE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]	
11. PLACE OF DEATH [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. MANNER OF DEATH [Illegible]		14. SIGNATURE OF MEDICAL EXAMINER [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF CORONER [Illegible]	
17. SIGNATURE OF JURY [Illegible]		18. SIGNATURE OF JUDGE [Illegible]	
19. SIGNATURE OF CLERK [Illegible]		20. SIGNATURE OF NOTARY [Illegible]	
21. SIGNATURE OF [Illegible] [Illegible]		22. SIGNATURE OF [Illegible] [Illegible]	
23. SIGNATURE OF [Illegible] [Illegible]		24. SIGNATURE OF [Illegible] [Illegible]	
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57. SIGNATURE OF [Illegible] [Illegible]		58. SIGNATURE OF [Illegible] [Illegible]	
59. SIGNATURE OF [Illegible] [Illegible]		60. SIGNATURE OF [Illegible] [Illegible]	
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63. SIGNATURE OF [Illegible] [Illegible]		64. SIGNATURE OF [Illegible] [Illegible]	
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67. SIGNATURE OF [Illegible] [Illegible]		68. SIGNATURE OF [Illegible] [Illegible]	
69. SIGNATURE OF [Illegible] [Illegible]		70. SIGNATURE OF [Illegible] [Illegible]	
71. SIGNATURE OF [Illegible] [Illegible]		72. SIGNATURE OF [Illegible] [Illegible]	
73. SIGNATURE OF [Illegible] [Illegible]		74. SIGNATURE OF [Illegible] [Illegible]	
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79. SIGNATURE OF [Illegible] [Illegible]		80. SIGNATURE OF [Illegible] [Illegible]	
81. SIGNATURE OF [Illegible] [Illegible]		82. SIGNATURE OF [Illegible] [Illegible]	
83. SIGNATURE OF [Illegible] [Illegible]		84. SIGNATURE OF [Illegible] [Illegible]	
85. SIGNATURE OF [Illegible] [Illegible]		86. SIGNATURE OF [Illegible] [Illegible]	
87. SIGNATURE OF [Illegible] [Illegible]		88. SIGNATURE OF [Illegible] [Illegible]	
89. SIGNATURE OF [Illegible] [Illegible]		90. SIGNATURE OF [Illegible] [Illegible]	
91. SIGNATURE OF [Illegible] [Illegible]		92. SIGNATURE OF [Illegible] [Illegible]	
93. SIGNATURE OF [Illegible] [Illegible]		94. SIGNATURE OF [Illegible] [Illegible]	
95. SIGNATURE OF [Illegible] [Illegible]		96. SIGNATURE OF [Illegible] [Illegible]	
97. SIGNATURE OF [Illegible] [Illegible]		98. SIGNATURE OF [Illegible] [Illegible]	
99. SIGNATURE OF [Illegible] [Illegible]		100. SIGNATURE OF [Illegible] [Illegible]	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Cancer		12801		CERTIFICATE OF DEATH				12776			
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>2 weeks</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>E.</u> Last <u>MILLER</u>					4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1959</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1915</u>		9. AGE (In years last birthday) <u>44</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sewnemaker</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Adam Mills</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Jane Adams</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>578-01-8746</u>					INFORMANT <u>Husband - Stanley F. MILLER</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1538</u> DUE TO <u>Intestinal Distention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous bowel</u> DUE TO (c) <u>Carcinomatous gen'l</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8:25</u> p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 27</u> , 19 <u>57</u> , to <u>27 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>27 Nov</u> , 19 <u>59</u> , and that death occurred at <u>209</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>W. S. Murphy</u> M.D.					ADDRESS (Street, city or town, state) <u>Rockville, Maryland</u> DATE SIGNED <u>11/27/59</u>						
PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR <u>DEC 2 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				

CERTIFICATE OF DEATH

1930

REPORT

1930

Decem 11 1930
New York City
John F. Miller
Age 45
Cause of Death
Heart Disease
U.S.A.

John F. Miller
Age 45
Cause of Death
Heart Disease
U.S.A.

John F. Miller
Age 45
Cause of Death
Heart Disease
U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12802

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12777

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 530 A Chester Street			
3. NAME OF DECEASED (Type or print) First William Middle Albert Last MILLER				4. DATE OF DEATH Month November Day 24 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-56		9. AGE (In years lost birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Raymond Miller				14. MOTHER'S MAIDEN NAME Margaret ALBERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT (Father) Albert R. Miller		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital Heart Disease (Common Ventricle) Post-operative state. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Operative state. (c) Operative state.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 October, 19 59 to 24 November, 19 59 that I last saw the deceased alive on 24 November, 19 59 and that death occurred at 9:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-24-99							
ACTUAL SIGNATURE Douglas R. Koth		M.D. U.S. Naval Hospital, Bethesda Md. 11-24-99					
PHYSICIAN'S NAME (Type) D.R. KOTH LCDR MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-27-59		22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Park		22d. LOCATION (City, town, or county) (State) Norfolk, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS 7557 Wisconsin, Ave. Bethesda Md.				24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE Charles E. K...	

051

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12808

Virginia

Honolulu

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

November 24

November 24

10-30-30

White

Male

U.S.

Virginia

Honolulu

Honolulu

Managers Office

U.S. Naval Hospital, Bethesda, Md.

November 24

Honolulu

Honolulu

(Doctor) Albert R. Miller

Boat no 12

November 24

November 24

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

November 24

November 24

U.S. Naval Hospital, Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12778

12803

1. PLACE OF DEATH a. COUNTY MONT GOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY - Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN '1b 2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8911 GEORGIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle H. Last MINTZER		4. DATE OF DEATH Month NOV. Day 6 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 23, 1892
9. AGE (In years last birthday) 67 yrs.		10. UNDER 1 YEAR Months 6 Days 7 Hours 15 Min.	11. UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSEUM WIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) N.Y. STATE		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BERNARD COHEN		14. MOTHER'S MAIDEN NAME GITEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. -	
17. INFORMANT DR MARTIN MINTZER		Address 8911 GEO. AVE. SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA SIGMOID COLON 153.3 DUE TO WITH LIVER METASTASIS Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO - DUE TO - DUE TO -			INTERVAL BETWEEN ONSET AND DEATH NO MOS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT. 16, 1959 to NOV. 6, 1959 , that I last saw the deceased alive on NOV. 6, 1959 , and that death occurred at 7:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Roberts		DATE SIGNED NOV. 6, 1959	
PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		ADDRESS (Street, city or town, state) 8907 GEORGIA AVE. SILVER SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF NOV. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY New York, N.Y.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th St. N.W.		24. REC'D BY REGISTRAR DATE NOV 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. King			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Nov. 1928

CERTIFICATE OF DEATH

Reg. Dist. No.

12804

12779

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 10 HRS. 25 MIN.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS		d. STREET ADDRESS 25605 RIDGE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MICHAEL BEAL MONTAGUE		First		Middle		Last		4. DATE OF DEATH Month NOVEMBER		Day 2		Year 19 59							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/2/59		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FRANCIS BEAL MONTAGUE								14. MOTHER'S MAIDEN NAME MARY ANNE LAWRENCE											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				INFORMANT HOSPITAL RECORDS				Address OLNEY, MARYLAND							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO (Birth weight 1 lb 12 oz) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOVEMBER 2, 19 59 , to NOVEMBER 2, 19 59 at I last saw the deceased alive on NOVEMBER 2, 19 59 , and that death occurred 6:35P M, from the causes and on the date stated above.																			
ACTUAL SIGNATURE M. McKendree Boyer, M. D.				ADDRESS (Street, city or town, state) Druid Theatre Building, DAMASCUS, MARYLAND				DATE SIGNED 11/3/59											
PHYSICIAN'S NAME (Type) M. M. BOYER, M. D.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-4-59				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Richmond Co.							
23. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Hanlon 3831-Georgia Ave NW								ADDRESS 20 7334 4XUO				24a. REC'D BY REGISTRAR DATE NOV 9 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12804

MONTGOMERY

MARYLAND

TO HER, 25 MIN. JANUARY

ONLY

MONTGOMERY COUNTY GENERAL HOSPITAL, INC. 2502 LINDS ROAD

NOVEMBER 21

MONTGOMERY

HER

MICHAEL

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11/25

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MARYLAND

MARY WHITE LAWRENCE

BRANDY HEAL HOSPITAL

HOSPITAL RECORDS

(MONTGOMERY 2 10 12 ON)

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NOVEMBER 21 1958

NOVEMBER 21

NOVEMBER 21 1958

MONTGOMERY

MONTGOMERY

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12805
CERTIFICATE OF DEATH

12780

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maitland 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			d. STREET ADDRESS Box 313		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle James Last MORGAN			4. DATE OF DEATH Month November Day 10 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-37		9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME Harold S. Morgan			12. CITIZEN OF WHAT COUNTRY? U.S.		
14. MOTHER'S MAIDEN NAME Nell WHITTY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 395 32 5159		INFORMANT Address (Wife) Sally J. Morgan Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 Aplastic Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 34 days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 31 October , 19 59 to 10 November , 19 59 that I last saw the deceased alive on 10 November , 19 59 and that death occurred at 8:05 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph E. Stitches M.D. U.S. Naval Hospital, Bethesda Md. 11-10-59 PHYSICIAN'S NAME (Type) J.E. STITCHER LT MC USN U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-59		22c. NAME OF CEMETERY OR CREMATORY Glennhaven Cemetery	
22d. LOCATION (City, town, or county) (State) Winter Park Florida					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 1400 Chapin St. N.W. Washington,				24a. REC'D BY REGISTRAR NOV 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur B. Kline	

12802

Montgomery

Postoffice (Pinal)

10 days

Postoffice

U.S. Naval Hospital, Bethesda Md.

Box 513

Medical

2000

Naval

Police

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U.S. Navy

U.S. Government

Washington

Medical S. Service

Naval Ministry

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10 November

31 November

10 November

U.S. NAVY OFFICE AT NO USE

U.S. Naval Hospital, Bethesda Md.

11-15-31

Glennville District

Naval Post Office

U.S. NAVY OFFICE AT NO USE

12685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JAMES Last MURRAY		4. DATE OF DEATH Month NOV Day 7 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-93
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min.	11. IF UNDER 24 HRS. Months 6 Days 12 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK-POST DEPT. N.Y.		10b. KIND OF BUSINESS OR INDUSTRY U.S. COIT	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MURRAY		14. MOTHER'S MAIDEN NAME ROSE COWAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT HOSP. RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Vascular Disease (c) years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-5 , 19 59 , to 11-7 , 19 59 , that I last saw the deceased alive on 11-7 , 19 59 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer M.D.		ADDRESS (Street, city or town, state) 1432 QUEENS CHAPEL RD DATE SIGNED	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER		Hyattsville Md 11-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 11, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Chambers Co. Inc.		ADDRESS Riverdale Md	
24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12685

DEATH

1-1-1911

1-1-1911

12686

CERTIFICATE OF DEATH

12782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12				c. LENGTH OF STAY IN 1b 3 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month 11 - Day 10 Year 1959				5. NAME OF DECEASED First Emmett Middle Hiram Last NANNA			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-87	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fed. Employee				10b. KIND OF BUSINESS OR INDUSTRY Ohio			
11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Vinton A. NANNA				14. MOTHER'S MAIDEN NAME Addie Sheldon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. pt's Hosp. Record			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive posterior coronary infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) acute (c) acute				INTERVAL BETWEEN ONSET AND DEATH acute			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10 , 19 56 , to Nov 10 , 19 59 , that I last saw the deceased alive on Nov 10 , 19 59 , and that death occurred at 9:35 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest A Sarao				ADDRESS (Street, city or town, state) 7006 New Hampshire Ave Takoma Park Md 11/10/59			
PHYSICIAN'S NAME (Type) Ernest A Sarao				DATE SIGNED 11/10/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial		22d. LOCATION (City, town, or county) (State) Moundville West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR NOV 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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2
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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Full Name of Deceased
Date of Birth
Place of Birth
Sex
Race
Marital Status
Occupation
Cause of Death
Date of Death
Place of Death
Signature of Physician
Signature of Registrar

Signature of Deceased
Date of Death
Place of Death
Signature of Registrar
Date of Death
Place of Death

12806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>D.</u> Last <u>Neff.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>9</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank De Fres</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>8 years</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>death</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>59</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marcel Foret</u>		ADDRESS (Street, city or town, state) <u>1746 K St N.W</u> DATE SIGNED <u>11/1/59</u>	
PHYSICIAN'S NAME (Type) <u>MARCEL FORET</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-5-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>FT. MYER, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Shivers Sons, 1756 P St N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of Illinois
 County of Cook
 City of Chicago

On this 22nd day of April 1901
 I, the undersigned, a Justice of the Peace in and for the County of Cook, State of Illinois, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the office of the undersigned.

CHIEF CLERK

12807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Agnes Last O'Reilly				4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 14 Hours 14 Min.		IF UNDER 24 HRS. Months 70 Days 14 Hours 14 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kirby				14. MOTHER'S MAIDEN NAME Margaret Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		INFORMANT Stephen O'Reilly Address 3732 Manor Road Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163x IMMEDIATE CAUSE (a) Terminal Bronchopneumonia DUE TO Carcinoma Epidermoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) right lung (c) 18 hours							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Sept 8 , 19 59 , to Nov 4 , 19 59 , that I last saw the deceased alive on Nov 4 , 19 59 , and that death occurred at 12:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle M.D. 5009 Del Ray Ave. Bethesda 11/4/59				ADDRESS (Street, city or town, state) Bethesda 11/4/59			
PHYSICIAN'S NAME (Type) Robert G. Angle 5009 Del Ray Ave., Bethesda, Md. 11/4/59				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS				24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Birth of child of Robert A. Franklin, born [illegible] at [illegible] New York City, New York, and of [illegible] born [illegible] at [illegible] New York City, New York.

Child's name: [illegible]
Sex: [illegible]
Date of birth: [illegible]
Place of birth: [illegible]
Time of birth: [illegible]
Weight: [illegible]
Length: [illegible]
Head circumference: [illegible]
Chest circumference: [illegible]
Arm circumference: [illegible]
Leg circumference: [illegible]
Foot length: [illegible]
Finger length: [illegible]
Middle finger length: [illegible]
Palm length: [illegible]
Palm width: [illegible]
Palm area: [illegible]
Palm volume: [illegible]
Palm thickness: [illegible]
Palm temperature: [illegible]
Palm color: [illegible]
Palm texture: [illegible]
Palm shape: [illegible]
Palm markings: [illegible]
Palm lines: [illegible]
Palm ridges: [illegible]
Palm scars: [illegible]
Palm moles: [illegible]
Palm freckles: [illegible]
Palm warts: [illegible]
Palm blisters: [illegible]
Palm ulcers: [illegible]
Palm tumors: [illegible]
Palm cysts: [illegible]
Palm abscesses: [illegible]
Palm fistulas: [illegible]
Palm sinuses: [illegible]
Palm veins: [illegible]
Palm arteries: [illegible]
Palm nerves: [illegible]
Palm muscles: [illegible]
Palm bones: [illegible]
Palm cartilages: [illegible]
Palm ligaments: [illegible]
Palm tendons: [illegible]
Palm joints: [illegible]
Palm skin: [illegible]
Palm hair: [illegible]
Palm nails: [illegible]
Palm teeth: [illegible]
Palm tongue: [illegible]
Palm throat: [illegible]
Palm chest: [illegible]
Palm stomach: [illegible]
Palm intestines: [illegible]
Palm bladder: [illegible]
Palm rectum: [illegible]
Palm anus: [illegible]
Palm penis: [illegible]
Palm vagina: [illegible]
Palm uterus: [illegible]
Palm ovaries: [illegible]
Palm fallopian tubes: [illegible]
Palm cervix: [illegible]
Palm endometrium: [illegible]
Palm myometrium: [illegible]
Palm perimetrium: [illegible]
Palm decidua: [illegible]
Palm placenta: [illegible]
Palm umbilical cord: [illegible]
Palm amnion: [illegible]
Palm chorion: [illegible]
Palm decidua parietalis: [illegible]
Palm decidua capsularis: [illegible]
Palm decidua basalis: [illegible]
Palm decidua vera: [illegible]
Palm decidua falsa: [illegible]
Palm decidua parietalis: [illegible]
Palm decidua capsularis: [illegible]
Palm decidua basalis: [illegible]
Palm decidua vera: [illegible]
Palm decidua falsa: [illegible]

1

Robert A. Franklin, born [illegible] at [illegible] New York City, New York, and of [illegible] born [illegible] at [illegible] New York City, New York.

Child's name: [illegible]
Sex: [illegible]
Date of birth: [illegible]
Place of birth: [illegible]
Time of birth: [illegible]
Weight: [illegible]
Length: [illegible]
Head circumference: [illegible]
Chest circumference: [illegible]
Arm circumference: [illegible]
Leg circumference: [illegible]
Foot length: [illegible]
Finger length: [illegible]
Middle finger length: [illegible]
Palm length: [illegible]
Palm width: [illegible]
Palm area: [illegible]
Palm volume: [illegible]
Palm thickness: [illegible]
Palm temperature: [illegible]
Palm color: [illegible]
Palm texture: [illegible]
Palm shape: [illegible]
Palm markings: [illegible]
Palm lines: [illegible]
Palm ridges: [illegible]
Palm scars: [illegible]
Palm moles: [illegible]
Palm freckles: [illegible]
Palm warts: [illegible]
Palm blisters: [illegible]
Palm ulcers: [illegible]
Palm tumors: [illegible]
Palm cysts: [illegible]
Palm abscesses: [illegible]
Palm fistulas: [illegible]
Palm sinuses: [illegible]
Palm veins: [illegible]
Palm arteries: [illegible]
Palm nerves: [illegible]
Palm muscles: [illegible]
Palm bones: [illegible]
Palm cartilages: [illegible]
Palm ligaments: [illegible]
Palm tendons: [illegible]
Palm joints: [illegible]
Palm skin: [illegible]
Palm hair: [illegible]
Palm nails: [illegible]
Palm teeth: [illegible]
Palm tongue: [illegible]
Palm throat: [illegible]
Palm chest: [illegible]
Palm stomach: [illegible]
Palm intestines: [illegible]
Palm bladder: [illegible]
Palm rectum: [illegible]
Palm anus: [illegible]
Palm penis: [illegible]
Palm vagina: [illegible]
Palm uterus: [illegible]
Palm ovaries: [illegible]
Palm fallopian tubes: [illegible]
Palm cervix: [illegible]
Palm endometrium: [illegible]
Palm myometrium: [illegible]
Palm perimetrium: [illegible]
Palm decidua: [illegible]
Palm placenta: [illegible]
Palm umbilical cord: [illegible]
Palm amnion: [illegible]
Palm chorion: [illegible]
Palm decidua parietalis: [illegible]
Palm decidua capsularis: [illegible]
Palm decidua basalis: [illegible]
Palm decidua vera: [illegible]
Palm decidua falsa: [illegible]

12808

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 70 X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 2317 Moss Street			
3. NAME OF DECEASED (Type or print)		First Curley Middle Neal Last Packer		4. DATE OF DEATH		Month November Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie W. Packer				14. MOTHER'S MAIDEN NAME Florence Willoughby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-23-59 , 19 59 , to 11-18-59 , 19 59 , that I last saw the deceased alive on 11-18-59 , 19 59 , and that death occurred at 12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/19/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Vincent T. Andriole		M.D. The Clinical Center		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Vincent T. Andriole, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/19/59		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		22d. LOCATION (City, town, or county) (State) Wilmington, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

UNITED STATES OF AMERICA

12508

Washington

to day

October

The Clinical Center, National Institutes of Health

301 North 34th Street

Washington, D.C. 20015

Phone (202) 775-6000

Director's Office

Dr. Robert A. Johnson

Dr. Robert A. Johnson

The Clinical Center

The Clinical Center

301 North 34th Street, Washington, D.C. 20015

Attention: Dr. Robert A. Johnson

Enclosed are two copies of

Div 12508

7-12-77

11-18-77

11-18-77

The Clinical Center

National Institutes of Health

301 North 34th Street

Washington, D.C. 20015

Enclosed are two copies of

Div 12508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12786

12809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11707 College View Dr.</u>			d. STREET ADDRESS <u>11707 College View Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>J.</u> Last <u>Papace</u>			4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/14</u>		9. AGE (In years last birthday) <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cartographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>		11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>	
13. FATHER'S NAME <u>JOHN PAPACE</u>			14. MOTHER'S MAIDEN NAME <u>VINCENZA BASILE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>113-03-9064</u>		17. INFORMANT <u>Mrs. Edith E. Papace, 11,707 College View Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema + Cerebral Anoxia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial Infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 12, 1959</u> , to <u>Oct 29, 1959</u> , that I last saw the deceased alive on <u>Oct 29, 1959</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19110 Georgia Ave. Silver Spring, Md.</u> DATE SIGNED <u>Nov 2, 1959</u>					
ACTUAL SIGNATURE <u>Edward J. Richards</u>		M.D. <u>19110 Georgia Ave. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. POMPHREY INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>733 Sligo Ave - apt 515</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>733 Sligo Ave - apt 515</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence Thomas Payne</u> First Middle Last 4. DATE OF DEATH <u>Nov 19 1959</u> Month Day Year				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-17-17</u> 9. AGE (In years last birthday) <u>42 yrs.</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salamanca</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cardiographia Petitioner</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dr. J. Payne</u> 14. MOTHER'S MAIDEN NAME <u>Marguerite Payne - Itin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW #2</u> 16. SOCIAL SECURITY NO. <u>WW #2</u> 17. INFORMANT <u>Marguerite Payne - Itin</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x</u> DUE TO <u>Acute Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aspiration of Gastric Contents</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute fatty metamorphosis</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>11/24/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u> 22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zappa</u>				24a. REC'D BY REGISTRAR <u>NOV 24 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12788**

12811

1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. 47X-9			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-9		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 1318 Sheridan Street N.W.			
3. NAME OF DECEASED (Type or print) John R. Pearson				4. DATE OF DEATH Month November Day 25 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, '71	9. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pearson				14. MOTHER'S MAIDEN NAME Fitzgugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Hosp Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery Thrombosis DUE TO Arterio sclerosis (c) Fracture of Rt hip						INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home					
20c. TIME OF INJURY Month, Day, Year 11-13 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschert M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11.28.59		22c. NAME OF CEMETERY OR CREMATORY CHANTILLY		22d. LOCATION (City, town, or county) (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert McNeill				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Robert McNeill	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

12687

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium and Hospital				1 d. STREET ADDRESS 715 Thayer Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Maxwell Peay First Middle Last				4. DATE OF DEATH November 3, 1959 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1890		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of Peace			10b. KIND OF BUSINESS OR INDUSTRY Montgomery County, Md.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown Peay				14. MOTHER'S MAIDEN NAME Isabelle Roach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-09-9568		INFORMANT Robert E. Peay Address 8516 Greenwood Ave, S.S. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Emboli. 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 day 1-3 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3-19 , 1954 , to 11/3 , 1959 , that I last saw the deceased alive on 11/2 , 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W B Wardrop MD				ADDRESS (Street, city or town, state) 800 Pershing Drive, Silver Spring, Md DATE SIGNED _____			
PHYSICIAN'S NAME (Type) William B. Wardrop							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/59		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE Robert E. Peay	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 42 hours after death.

CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12812
CERTIFICATE OF DEATH

12790
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3317 5th Street S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Francis PERRAULT		4. DATE OF DEATH Month Day Year November 5 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-59
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days 2 19	11. IF UNDER 24 HRS. Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis F. PERRAULT		14. MOTHER'S MAIDEN NAME Helen LANNAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT (Father) Louis F. Perrault		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and dehydration DUE TO 053.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Neglected upper respiratory infection with ? pneumococcus septicemia DUE TO (c) Renal shutdown		INTERVAL BETWEEN ONSET AND DEATH 1. day 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 November 1959 , to 5 November 1959 , that I last saw the deceased alive on 5 November 1959 , and that death occurred at 9:00P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED G.B. Avery U.S. Naval Hospital, Bethesda Md. 11-5-59			
ACTUAL SIGNATURE G.B. AVERY LT MC USN		PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-59	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Lowell Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE R. M. Humphrey		ADDRESS 455 Wisconsin Ave. Bethesda Md.	
24a. REC'D BY REGISTRAR NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Fenn	

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Director of Columbia

Washington

1 day

Rebecca (Mrs.)

3317 5th Street S.E.

U.S. Naval Hospital, Bethesda Md.

PERMANENT

Permanent

James

8-11-39

White

Male

Massachusetts

None

None

Helen T. HAN

James V. PERMANENT

(Editor) James V. PERMANENT

None

None

*Check and delivery
No. 11-7-39
U.S. Naval Hospital, Bethesda Md.*

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U.S. Naval Hospital, Bethesda Md. 11-7-39

U.S. Naval Hospital, Bethesda Md.

O.S. WALKER

Novell Press

Dr. Peterson's Company

11-7-39

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U.S. Naval Hospital, Bethesda Md.

12813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 612 Mellon St. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST H. PERRY				4. DATE OF DEATH Month Day Year NOV. 10, 1959			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18-1910	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction Whitehall N.Y.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Robert Perry				14. MOTHER'S MAIDEN NAME Sylvia Blanchard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO.		17. INFORMANT Address Ethel M. Perry 612 Mellon St. S.E. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 3, 1959 , to Nov. 9, 1959 , that I last saw the deceased alive on Nov. 9, 1959 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1331 STAPLES ST. WASH. D.C. DATE SIGNED Wm. J. P. Howard							
ACTUAL SIGNATURE Wm. J. P. Howard M.D.							
PHYSICIAN'S NAME (Type) Wm. J. P. Howard							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. Chambers Co. Inc. Washington, D.C.				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18813

Reg. No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. SMITH		Male		45		Jan 15, 1836		New York		Farmer	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		OTHER	
MARRIED		SINGLE		MARRIED		DIVORCED		WIDOWED		OTHER	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Jan 15, 1836		New York		Jan 15, 1881		New York		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
Jan 15, 1881		New York		Heart Disease		Natural		Jan 15, 1881		New York	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
Jan 15, 1881		New York		Heart Disease		Natural		Jan 15, 1881		New York	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
Jan 15, 1881		New York		Heart Disease		Natural		Jan 15, 1881		New York	

RECEIVED BY

18813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

CERTIFICATE OF DEATH

12792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY CHASE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>15006 DALTON RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>RALPH PERRY</u>				4. DATE OF DEATH <u>Nov. 16, 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 2, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEFT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY YARD</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JAMES PERRY</u>				14. MOTHER'S MAIDEN NAME <u>IDA WARD PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>LOUISE M BOYD</u>				Address <u>5007 DALTON RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>10 day</u> Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 6, 1959</u> to <u>present</u> , that I last saw the deceased alive on <u>Nov. 16, 1959</u> and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.P. Ryland</u>				ADDRESS (Street, city or town, state) <u>4400 - 49th St. N.W. Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>C.P. RYLAND, M.D.</u>				DATE SIGNED <u>Nov. 18 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment 11/17/59</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	
22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>Home</u>		24. REC'D BY REGISTRAR <u>Nov 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in 24 hours after death, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12793

12688

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		d. STREET ADDRESS <u>17504 WILDWOOD DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>AGNES</u> Last <u>PICARD</u>		4. DATE OF DEATH <u>NOVEMBER 2, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 4, 1887</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIS KNOTT</u>		14. MOTHER'S MAIDEN NAME <u>MARY FITZGIBBONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS DANIEL HAMMOND, 7504 WILDWOOD DR</u>		Address <u>TAK. PK. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>593X Uremia</u> DUE TO (b) <u>hepatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hepatic</u> DUE TO (c) <u>hepatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1949</u> , to <u>Nov 2, 1959</u> , that I last saw the deceased alive on <u>Nov 2, 1959</u> , and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon C. Weiner</u> M.D.		ADDRESS (Street, city or town, state) <u>100 Longfellow St. N.W. Wash. D.C. 14-259</u>	
PHYSICIAN'S NAME (Type) <u>SIMON C. WEINER</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Nov 6, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westerly, Rhode Island</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		ADDRESS <u>WASH. DC</u>	
24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1900

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		45		1855		Maryland		Baltimore		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
Carpenter		Heart Disease		Natural		Several Months		Jan 10, 1900		10:00 AM		Home		Baltimore	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		DIAGNOSIS		PROGNOSIS		MEDICAL ATTENDANT		NURSE		OTHER	
None		Chest pain, shortness of breath		Medicine, rest		Heart Disease		Poor		Dr. J. H. Harris		None		None	
EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		OTHER	
High School		Roman Catholic		Married		Yes		No		No		No		No	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
James H. Harris		Mary H. Harris		Carpenter		Homemaker		Maryland		Maryland		1855		1855	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
Jan 10, 1900		10:00 AM		Home		Baltimore		Baltimore		Maryland		None		None	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
Jan 10, 1900		10:00 AM		Home		Baltimore		Baltimore		Maryland		None		None	

STATE OF MARYLAND
BALTIMORE
JAN 10 1900
JAMES H. HARRIS
Carpenter
Heart Disease
Natural
Several Months
Jan 10, 1900
10:00 AM
Home
Baltimore
Baltimore
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12794

12689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u> <u>46x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Castle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RALLS Nursing Home</u>		d. STREET ADDRESS <u>Route #1, Box 80</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Jane</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1876</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bertram Dumire</u>		14. MOTHER'S MAIDEN NAME <u>Mariok ARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Nelle W. Livingston</u>		Address <u>9001 Miles St. Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis 30 years</u> DUE TO (c) <u>Hypertensive cardiovascular disease years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/6</u> , 1956, to <u>11/25</u> , 1959, that I last saw the deceased alive on <u>Nov. 23</u> , 1959, and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace N. Mook</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Carroll Avenue</u> DATE SIGNED <u>11/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Wallace N. Mook MD</u>		<u>Takoma Park 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov. 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Braceburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u>Nov 27 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]	
TIME OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	


 10-11-1914

UC

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH.
 PHYSICIAN.

12815

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3½ days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Aldia Last Ricketts		4. DATE OF DEATH Month 11 Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/29/02
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 8 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Augustus Ricketts		14. MOTHER'S MAIDEN NAME Mary Susan Ricketts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-14-8432	
INFORMANT Mrs. Helen Bogdanski - 407 Carl St., Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infection 465x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pulmonary embolism 002x DUE TO (b) 3 hours (c) 3 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculous Tuberculosis, Upper lobe left lung			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15-59 , to 11-19-59 , that I last saw the deceased alive on 11-19-59 , and that death occurred at 3:15 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray, Jr.		DATE SIGNED 11/20/59	
PHYSICIAN'S NAME (Type) Geo. H. Gray, Jr. M.D.		Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/59	
22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR NOV 23 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

1. The Director: After this certificate is signed by the physician and completely filled in by the funeral home, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral home for to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

Name of Deceased: John Doe
 Sex: Male
 Age: 45
 Date of Birth: Jan 15 1878
 Place of Birth: London, England
 Date of Death: Dec 10 1923
 Place of Death: New York City, N.Y.
 Cause of Death: Heart Disease
 Signature of Physician: Dr. J. H. Smith
 Signature of Registrar: John Doe

This is to certify that the above named person died on the 10th day of December 1923 at the age of 45 years.
 The cause of death was Heart Disease.
 Signed and sealed this 15th day of December 1923.
 Registrar: John Doe
 Date: Dec 15 1923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12690

CERTIFICATE OF DEATH

12796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		
c. LENGTH OF STAY IN 1b <u>2/15/59-11/2/59</u>			d. STREET ADDRESS <u>3700 39th St., N.W.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SARAH (NMN) Rome</u>			4. DATE OF DEATH <u>NOV 2 1959</u>		
5. SEX <u>♀</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-89</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Russia</u>		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>		
13. FATHER'S NAME <u>Solomon Ritzenberg</u>			14. MOTHER'S MAIDEN NAME <u>Nellie Daitch</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		
17. INFORMANT <u>MARTIN WATMAN</u>			Address <u>3700-39th St. N.W. DC</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) <u>1 MONTH</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>59</u> , to <u>11/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>59</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Samuel V. N. Sugar</u> M.D.			ADDRESS (Street, city or town, state) <u>4300 KAYWOOD DRIVE</u> DATE SIGNED <u>11/2/59</u>		
PHYSICIAN'S NAME (Type) <u>SAMUEL V. N. SUGAR</u>			MT PAINIER, MD.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>11/4/59</u>	<u>NATK. MEM. PARK</u>	<u>Falls Church, Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>			ADDRESS <u>4217-9th St. NW</u>		
24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE		
DATE <u>NOV 5 '59</u>			<u>Arthur S. Harris</u>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12797

12816

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3942 WASHINGTON ST.		e. STREET ADDRESS 3942 WASHINGTON ST.	
3. NAME OF RACHEL DECEASED (Type or print) VIRGINIA WAUGH RONSAVILLE		4. DATE OF DEATH Month NOVEMBER Day 8 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 22, 1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER retired		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES EDWIN WAUGH		14. MOTHER'S MAIDEN NAME SARAH VICTORIA McKELDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT MISS VIRGINIA RONSAVILLE, 3942 Washington St.,		Address Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular renal disease DUE TO (c) 12 hr 17 yrs			INTERVAL BETWEEN ONSET AND DEATH 12 hr 17 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Fell on bed room floor - Smiley			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DATE SIGNED 11-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/12/59	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Raymond A. Ziska		24c. REGISTRAR'S SIGNATURE C. J. L. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

DEPARTMENT OF HEALTH

MARYLAND

HARTFORD

SMITHSONIAN

STATE OF MARYLAND

WASHINGTON

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WASHINGTON

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VERGILIA MADON BOWEN

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 11 & 12 Film G252 11/18/59 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

12798

12817

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>2 mos 25 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmer Sanitarium - Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6013 - Eastern Ave. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MARIE ROULEAU</u>		4. DATE OF DEATH Month Day Year <u>NOV. 5 1959</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 18, 1878</u>		9. AGE (In years last birthday) <u>80</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.				
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Thomas Ward</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MRS. ANNA Ogden - 6013 - Eastern Ave.</u>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 UREMIA</u> DUE TO <u>RENAL FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN'L ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>2-3 days</u> <u>10+ years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I attended the deceased from <u>10/12, 1959</u> , to <u>11/5, 1959</u> , that I last saw the deceased alive on <u>11/4, 1959</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 CATTARAUGUS AVE. WASHINGTON, D.C.</u> DATE SIGNED <u>11/5/59</u> ACTUAL SIGNATURE <u>Charles J. Savarese, M.D.</u> PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, M.D. BETHESDA MD</u>																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>Nov. 9 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulcher Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Philadelphia Penn.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>						24. REC'D BY REGISTRAR ADDRESS <u>1400 Chapin St. N.W. Wash., D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		DATE <u>NOV 9 '59</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

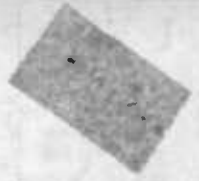
12799

12818

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10807 Kenilworth Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle E Last Rucker				4. DATE OF DEATH Month Nov. Day 11 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/4/1874	
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 6 Days 7		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-retired				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Benjamin L Rucker				14. MOTHER'S MAIDEN NAME Sally Parks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Clara M Rucker-sister-same as 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic Heart Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 10 , 19 59 , to Nov. 11 , 19 59 , that I last saw the deceased alive on Nov. 11 , 19 59 , and that death occurred at 10:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Marion Bankhead M.D.				ADDRESS (Street, city or town, state) 9241 Col. Blvd 11/14/59			
PHYSICIAN'S NAME (Type) J. Marion Bankhead				Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/59		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur A. Hanks			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1 12819 128800 1 050 1 2 1 VS A15 (4) ISM 9/58 BP TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 050 1 2 1 VS A15 (4) ISM 9/58 BP

12819

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1301 15th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fred Middle Harry Last Rylander				4. DATE OF DEATH Month November Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1894	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Rylander				14. MOTHER'S MAIDEN NAME Christina Waldo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 554-18-4822		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Severe generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 12 19 59 to November 23, 19 59 , that I last saw the deceased alive on November 23, 19 59 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor W. Sidel		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

12813
CENTRAL OF DEATH

Director of Columbia

Washington

The Clinical Center, Bethesda, Md. 20814

November 23, 1955

July 27, 1955

U.S.A.

Christian White

52-12-1022, The Clinical Center, Bethesda, Md., Maryland

Acute experimental influenza

Acute experimental influenza

November 23, 1955

The Clinical Center
National Institutes of Health
Bethesda 14, Maryland

Director, N.D.

November 23, 1955

12820

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>3 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>3416 RITTENHOUSE ST. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES SAMUEL SCHERMERHORN</u>				4. DATE OF DEATH Month Day Year <u>11 15 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/13/1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESIDENT OF ART SHOP</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ART</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD SAMUEL SCHERMERHORN</u>				14. MOTHER'S MAIDEN NAME <u>BELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>DOROTHY (WIFE)</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1959</u> to <u>November 15, 1959</u> , that I last saw the deceased alive on <u>November 14, 1959</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Roger Kurtz, M.D.</u>		M.D.		ADDRESS (Street, city or town, state) <u>3701 Connelley St. Wash. 8 D.C.</u>		DATE SIGNED <u>11-15-59</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Harris Co</u>				ADDRESS <u>2901-14th St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur & Harris</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1880

STATE OF NEW YORK

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CERTIFICATE OF DEATH

12802

Reg. Dist. No.

MONTGOMERY COUNTY

1. PLACE OF DEATH a. COUNTY <u>Resmor Sanitarium</u> <u>5721 Grosve nor Lane Bethesda</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Bethesda, Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR Sanitarium</u>		d. STREET ADDRESS <u>17311 Delfield St.</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Nora Elizabeth Scott</u>		4. DATE OF DEATH Month <u>Nov</u> , Day <u>19</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26, 1865</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>	
13. FATHER'S NAME <u>James Scott</u>		14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Atwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Capt. James Scott II</u>		Address <u>17311 Delfield St Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO <u>arteriosclerotic heart disease</u> (c) <u>20 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3-4 weeks</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month <u> </u> Day <u> </u> Year <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>19 Dec, 1958</u> , to <u>19 Nov, 1959</u> , that I last saw the deceased alive on <u>11/18, 1959</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>4890 BATTERY LA</u>	
DATE SIGNED <u>11/19/59</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR. MD</u>		<u>BETHESDA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co.</u>		ADDRESS <u>1400 Chapin St NW Wash, D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Robert S. Kline</u>
24a. REC'D BY REGISTRAR <u>DATE NOV 20 '59</u>			

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12822

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5201 SARATOGA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LYDIA Middle E Last SCRIVENER		4. DATE OF DEATH Month 11 Day 3 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1879
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME -- Emmons		14. MOTHER'S MAIDEN NAME Lucy Conant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Milton E. Scrivener-5201 Saratoga Ave.		Address Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Coronary heart disease Myocardial infarction DUE TO (c) 7 days		INTERVAL BETWEEN ONSET AND DEATH 4 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Obliterans - Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15 , 19 57 , to 11-3 , 19 59 that I last saw the deceased alive on 10-31-59 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Andrew G. Prandoni		M.D.	
PHYSICIAN'S NAME (Type) Andrew G. Prandoni		1150 Conn. Ave., N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/59	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
ADDRESS Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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13222

MONTGOMERY

CHRYSLER

2201 CANADIAN AVENUE

2201 CANADIAN AVENUE

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Aug. 2, 1972

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Wilson S. ...

Gray ...

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

CERTIFICATE OF DEATH

Reg. Dist. No.

12823

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Adgate Last Sexsmith		4. DATE OF DEATH Month November Day 2 Year 19 59.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Methodist Church	9. AGE (In years last birthday) yrs. 84
11. BIRTHPLACE (State or foreign country) Clark County, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Sexsmith		14. MOTHER'S MAIDEN NAME Mary Boyle Owings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Paul E. Keedy - 3116 Grindon Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO (c) central vascular accident			INTERVAL BETWEEN ONSET AND DEATH 10-31-59 10-21-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1955 , to Nov 2, 1959 , that I last saw the deceased alive on Nov 2, 1959 , and that death occurred at 11 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 Cedar Lane Kensington, Md.	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.		DATE SIGNED 11-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Pickner & Sons - Balto		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No 215

12824

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 12818 Flack Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last SINOPOLI			4. DATE OF DEATH Month November Day 5 Year 19 59				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-05	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia,			
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Joseph LOCKE				
14. MOTHER'S MAIDEN NAME Mamie LAMBATH			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. INFORMANT (Husband) Jack Sinopoli			Address Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary Congestive Atelectasis 570.5 DUE TO (b) post op complication INTESTINAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) OBSTRUCTION							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 28 October , 19 59 , to 5 November , 19 59 , that I last saw the deceased alive on 5 November , 19 59 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 11-6-59							
ACTUAL SIGNATURE C. U. Bramlett		M.D. U.S. Naval Hospital, Bethesda Md.					
PHYSICIAN'S NAME (Type) C. U. BRAMLETT LT MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington Va.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey		ADDRESS 8434 Georgia Ave. Silver Spring Md.	24a. REC'D BY REGISTRAR NOV 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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STATE OF DEATH

Married

Silver Spring

12818 Main Street

Silver Spring

11-21-07

Director of Police

James J. ...

(Husband) Jack Simpson - Born in ...

Residence (Husband)

U.S. Naval Hospital, Bethesda Md.

Married

White

One

Joseph ...

No

23 October

23 November

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Washington National

Washington D.C.

U.S. Navy, Silver Spring Md.

1 ~~X~~ ~~M~~ ~~copy~~ ~~E.J.~~
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G253 12-14-59 et

12806

12825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 142 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg, 85 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route 2, Box 20			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First JESSIE Middle HAZEL Last SPANGLER		4. DATE OF DEATH		Month November Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1906		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Edgar Goff				14. MOTHER'S MAIDEN NAME Marcella Dunbar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Clinical Center Address Medical Record The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension, Essential							INTERVAL BETWEEN ONSET AND DEATH 1-2 hours 2 years 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1959 to November 30, 1959 that I last saw the deceased alive on November 30, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/1/59 ACTUAL SIGNATURE Louis Gillespie, Jr. M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Louis Gillespie M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) NEWBURG, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Sines Co.				ADDRESS 2901 14th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE DEC 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12882

The undersigned, being a duly qualified medical practitioner, hereby certify that on the 25th day of September 1952, at the residence of the deceased, I examined the body of the deceased and found that the cause of death was as stated on the certificate of death.

Signature of Medical Practitioner
Name of Medical Practitioner
Address of Medical Practitioner

Witnessed by me, the Registrar General, on the 25th day of September 1952, at the residence of the deceased.

Signature of Registrar General
Name of Registrar General
Address of Registrar General

Issued by the Registrar General, Western Australia

12691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 901 MAPLEWOOD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WARREN First SPANGLER Middle Last		4. DATE OF DEATH NOV. Month 2 Day 19 Year 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/80
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (retired)		10b. KIND OF BUSINESS OR INDUSTRY Oil City Water Co.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL SPANGLER		14. MOTHER'S MAIDEN NAME ANNA JOHNSTONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE	
17. ADDRESS (If yes, give war or dates of service)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1959 to Nov. 2, 1959 that I last saw the deceased alive on Nov 2, 1959 , and that death occurred at 4:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4500 Columbia Rd DATE SIGNED ACTUAL SIGNATURE H. B. ORLEANS M.D. Silver Spring Md PHYSICIAN'S NAME (Type) H. B. ORLEANS		22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 22b. DATE THEREOF 11/2/59 22c. NAME OF CEMETERY OR CREMATORY SUNSET MEM. CEMETERY 22d. LOCATION (City, town, or county) (State) VENANGO COUNTY, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 3 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13081

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 12808

12826

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Silver Spring				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Northwest Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 410 Northwest Drive	
3. NAME OF DECEASED (Type or print) Ernst Gustav Heinrich Sprick				4. DATE OF DEATH Month November Day 16 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1891		9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 6 Days 16 Hours 19 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? West Germany	
13. FATHER'S NAME Albrecht Sprick				14. MOTHER'S MAIDEN NAME Emelie Siekmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT 410 Northwest Drive Johanna Sprick Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July 7, 1959 , to Nov. 16, 1959 , that I last saw the deceased alive on November 16, 1959 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Norman H. Rubenstein M.D. 6480 New Hampshire Ave. Takoma Park, Md. PHYSICIAN'S NAME (Type) Norman H. Rubenstein, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Sprick Family Cemetery		22d. LOCATION (City, town, or county) (State) Glengary, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE NOV 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1910

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12827

CERTIFICATE OF DEATH

Reg. Dist. No.

12809

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10737 Colesville Road				d. STREET ADDRESS 6800 Connecticut Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EUFROSYNE		First		Middle STAMATIS		Last	
4. DATE OF DEATH Month November Day 15 Year 19 59		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/2/1870		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 9 Days 13		11. IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME Manual Daskalakis			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				INFORMANT John Theodore-son-in-law-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Metastatic CA. Primary pelvis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4 , 19 59 , to 11/15 , 19 59 , that I last saw the deceased alive on 11/12 , 19 59 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. F. Thibadeau				ADDRESS (Street, city or town, state) 10114 Colesville Rd. Silver Spring, Md.		DATE SIGNED 11/16/59	
PHYSICIAN'S NAME (Type) A. F. Thibadeau							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

12821

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12828

CERTIFICATE OF DEATH

Reg. Dist. No.

12810

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE SAME - MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 565 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10105 MCKENNEY AVE.				d. STREET ADDRESS 10105-MCKENNEY AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEO Middle NONE Last STERN				4. DATE OF DEATH Month NOV Day 11 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10 1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 4 Days 1	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT			10b. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISAAC STERN				14. MOTHER'S MAIDEN NAME CAROLINE ROTHCHILD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT HELEN STERN Address WIFE 10105-MCKENNEY AV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 8 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) 		(County) (State) 	
21. I certify that I attended the deceased from MAY , 19 59 , to NOV 11 , 19 59 , that I last saw the deceased alive on NOV 9 , 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10211 GEORGIA AVE DATE SIGNED 11/11/59							
ACTUAL SIGNATURE Henry W. Stout M.D.				ADDRESS SILVER SPRING MD.			
PHYSICIAN'S NAME (Type) HENRY W. STOUT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY + SONS				ADDRESS 3501-14TH ST NW		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12811

Reg. Dist. No.

12829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3911 Aspen St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Ann Stouffer</u>				4. DATE OF DEATH Month Day Year <u>Nov. 24 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug. 2, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Voice Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>		11. BIRTHPLACE (State or foreign country) <u>Canton, Ill</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Terah Smith</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Dancer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>223-30-4925</u>		17. INFORMANT Address <u>Same as Above</u> <u>Daughter M rs. A. Thurston</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11-24-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 11/27/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Canton, Illinois</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

12830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 45 New York Ave., N.W.			
3. NAME OF DECEASED (Type or print) First Evelyn Middle A. Last Stuart				4. DATE OF DEATH Month November Day 21 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/13	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.		IF UNDER 24 HRS. Months 46 Days 46 Hours 46 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Avon Representative				10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edmund W. Lingebach				14. MOTHER'S MAIDEN NAME Rose M einberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Yes			
17. INFORMANT Hilda M. Raedy 9003 Wellington St. Sebrook, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive spontaneous subarachnoid hemorrhage (sister) 330X Hypertensive vascular disease and probably Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. congenital cerebral aneurysm. DUE TO (b) ? DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 11 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-20-59 , to 11-21-59 , that I last saw the deceased alive on 11-21-59 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Gray, Jr. M.D.				ADDRESS (Street, city or town, state) 4422 East-west Hwy, -11/21/59.			
PHYSICIAN'S NAME (Type) Geo. A. GRAY, JR. MD. Bethesda 14, Md.				DATE SIGNED 11/21/59.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/24/59			
22c. NAME OF CEMETERY OR CREMATORY Tr. Lincoln				22d. LOCATION (City, town, or county) (State) Colman Manor Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon ADDRESS -3831- Galt Rd				24a. REC'D BY REGISTRAR DEC 2 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Haulon							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

1

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12831

12813

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg 85 x -3				d. STREET ADDRESS No Street Address			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Richard Last Stump				4. DATE OF DEATH Month November Day 29 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 26, 1954	
9. AGE (In years lost birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.		IF UNDER 24 HRS. Months 5 Days 5 Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Elwood Grant Stump				14. MOTHER'S MAIDEN NAME Mayselle J. Riggleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Upper Respiratory & Gastro Intestinal Bleeding DUE TO (c) Acute Lymphatic Leukemia INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 days 9 mon.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.3							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 8, 1959 , to November 29, 1959 , that I last saw the deceased alive on November 29, 1959 , and that death occurred at 12:15 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/29/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Jerry S. Trier M.D. The Clinical Center 11/29/59 PHYSICIAN'S NAME (Type) Jerry S. Trier M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY Tahmansville Cemetery		22d. LOCATION (City, town, or county) (State) Thamansville, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE DEC 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1941

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CERTIFICATE OF DEATH

12814

Reg. Dist. No.

12832

1. PLACE OF DEATH a. COUNTY MONTGOMERY County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 18 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA WOODLAND Sdn.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle KING Last SYMNER				4. DATE OF DEATH Month NOV. Day 5 Year 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 15, 1875	
9. AGE (In years last birthday) 88 1/4 yrs.		10. UNDER 1 YEAR Months 11 Days 15 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMM. ARTIST				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13. FATHER'S NAME JOHN HOLMES STONE				14. MOTHER'S MAIDEN NAME SUSAN M. KING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. INFORMANT Address NURSING HOME RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary edema							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease et. 10 yrs. DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Accident (Thrombosis)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug , 19 59 , to Nov 5 , 19 59 , that I last saw the deceased alive on Nov 4 , 19 59 , and that death occurred at 4 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph E. Patten M.D.				ADDRESS (Street, city or town, state) 864-Colesville Road DATE SIGNED 11/4/59			
PHYSICIAN'S NAME (Type) RALPH E. PATTEN M.D.				864-Colesville Road			
22a. BURIAL, CREMATION, or other disposition of body CREMATION		22b. DATE THEREOF 11/6/59		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		22d. LOCATION (City, town, or county) (State) SUITLAND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Baker's Son ADDRESS 1756 PA. AVE., N.W. DC				24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12282

REPORT BY

DATE

PLACE OF DEATH

DECEASED

AGE

SEX

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

12833

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Wooster e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOROTHY Middle MAE Last TAYLOR				4. DATE OF DEATH Month November Day 3 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1941	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 18		IF UNDER 24 HRS. Days 18		Hours 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Paul Taylor				14. MOTHER'S MAIDEN NAME Leta Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unavailable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebellar hemorrhage 173X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Choriocarcinoma DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) WOOSTER OHIO				20g. (County) WOOSTER OHIO		20h. (State) WOOSTER OHIO	
21. I certify that I attended the deceased from October 27, 19 59 , to November 3, 19 59 , that I last saw the deceased alive on November 3, 19 59 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-4-59							
ACTUAL SIGNATURE Saul Genuth				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Saul Genuth, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIPRA				22b. DATE THEREOF 11-5-59		22c. NAME OF CEMETERY OR CREMATORY WOOSTER OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE U.W. Chambers Co				ADDRESS 1400 Chapin St N		24a. REC'D BY REGISTRAR NOV 5 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Knepp							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Mountainside c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67x-3 d. STREET ADDRESS 1291 Cedar Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUBY Middle SUSAN Last THIES		4. DATE OF DEATH Month November Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1916
9. AGE (In years lost birthday) yrs. 43		10. IF UNDER 1 YEAR Months 4 Days 3 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Koingsfeld		14. MOTHER'S MAIDEN NAME Sophia Berg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 320-01-5367	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Artrial Septal Defect DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days Life			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 25, 1959 to November 3, 1959 , that I last saw the deceased alive on November 3, 1959 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-4-59			
ACTUAL SIGNATURE E. C. Brockenbrough, M.D.		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) E. C. Brockenbrough, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-trans	22b. DATE THEREOF 11/5/1959	22c. NAME OF CEMETERY OR CREMATORY Hillside	22d. LOCATION (City, town, or county) (State) Plainfield New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey Bethesda, Maryland

Birth - 11/5/1929

Allyside

Princeton, New Jersey

W. C. Proctor, M.D.

John M. Proctor, M.D.

John M. Proctor, M.D.

John M. Proctor, M.D.

John M. Proctor, M.D.

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John M. Proctor, M.D.

John M. Proctor, M.D.

John M. Proctor, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12817

Reg. Dist. No.

12835

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>					d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/33</u>		9. AGE (In years last birthday) <u>25</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>M aryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Awkward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Caroline Thomas, Sandy Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Hemorrhage</u> DUE TO (b) <u>Rupture of liver & Rt. Kidney</u> DUE TO (c) <u>Auto accident</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound fractures of rt. arm & forearm</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto invlived in accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:53</u> <u>PM</u> <u>11/14</u> <u>19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Brookville Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/15/59</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12692

CERTIFICATE OF DEATH

Reg. Dist. No.

12818

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium Hosp.</i>				d. STREET ADDRESS <i>6005 Sisson ST</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. A BRAM</i> Middle <i>(NMN)</i> Last <i>Thorne</i>				4. DATE OF DEATH Month <i>11</i> Day <i>24</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-86</i>		9. AGE (In years lost birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dress Designer</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>
13. FATHER'S NAME <i>Herman Thorne</i>				14. MOTHER'S MAIDEN NAME <i>Yetta Beck</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>UNKNOWN</i>		INFORMANT <i>Robert Thorne</i>		Address <i>S.S. 655 Sisson ST.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure with Pulmonary Edema</i> DUE TO (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 Hours</i> <i>8 Hours</i> <i>5 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> , to <i>11/24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/24 4:10 PM</i> , 19 <i>59</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Stuart L. Nelson</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>7600 Carroll Avenue, Takoma Park, Md.</i>			
PHYSICIAN'S NAME (Type) <i>STUART L. NELSON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>Nov. 27, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>OLD MT. CARMEL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>QUEENS N. Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. DANZANSKY & SONS - 3501-14th ST. N.W.</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

COPIES OF DEATH CERTIFICATE

1922

1922

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1922

12836

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Harry Last Towbes				4. DATE OF DEATH Month November Day 2 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1898	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Towbes				14. MOTHER'S MAIDEN NAME Golda Levy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. Unascertainable			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia DUE TO (c) Acute Myelocytic Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours 3 1/2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 26, 1959 , to November 2, 1959 , that I last saw the deceased alive on November 2, 1959 , and that death occurred at 6:21 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 11/2/59 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Jerry S. Trier				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				24a. REC'D BY REGISTRAR NOV 4 '59			
ADDRESS 3501 14th Street, N.W.				24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Ministry of Columbia

Washington

1230 15th Street, N.W.

November 2

James

Harry

Louis

61

June 20, 1898

x

White

Male

Ministry of Columbia

Neel Estate

Real Estate Broker

James Augustus Golda Levy

The Medical Record

Unaccountable The Clinical Center, Bethesda 11, Maryland

W.H.

Yes

24 hours

lobar pneumonia

24 hours

pneumonia

24 hours

acute infectious pneumonia

October 26 November 2 - 29

November 2 - 29

The Clinical Center
National Institution of Health

Bethesda 11, Maryland

Harry C. Frier, M.D.

Nov. 2, 1959 King 11-14 Research Station 11, Maryland

E. Dunnison & Son, 1111 11th Street, N.W.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton 13x-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County Gen. Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mark Middle Allen Last Trail				4. DATE OF DEATH 11/20/59 Month 11 Day 20 Year 1959				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/29/56		
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 10 Hours 20 Min.		IF UNDER 24 HRS. Hours 20 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gerald Trail				14. MOTHER'S MAIDEN NAME Mable E. Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp Record		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of peptic ulcer of stomach DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH one week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Breschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) Frank J. Breschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORY Linthicum Chapel		22d. LOCATION (City, town, or county) (State) Clarksville, Md		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN ALLEN CRILL		2. SEX Male	
3. AGE 30		4. RACE White	
5. DATE OF DEATH April 1, 1933		6. TIME OF DEATH 11:00 AM	
7. PLACE OF DEATH Home		8. OCCUPATION None	
9. MARITAL STATUS Single		10. EDUCATION None	
11. BIRTHPLACE Maryland		12. PRESENT RESIDENCE Baltimore, Maryland	
13. DATE OF BIRTH April 1, 1903		14. PLACE OF BIRTH Baltimore, Maryland	
15. NAME OF PHYSICIAN Dr. J. H. H. H.		16. NAME OF SURGEON None	
17. NAME OF PATHOLOGIST None		18. NAME OF ANATOMIST None	
19. NAME OF BACTERIOLOGIST None		20. NAME OF CHEMIST None	
21. NAME OF RADIOLOGIST None		22. NAME OF ENTOMOLOGIST None	
23. NAME OF ENTOMOLOGIST None		24. NAME OF ENTOMOLOGIST None	
25. NAME OF ENTOMOLOGIST None		26. NAME OF ENTOMOLOGIST None	
27. NAME OF ENTOMOLOGIST None		28. NAME OF ENTOMOLOGIST None	
29. NAME OF ENTOMOLOGIST None		30. NAME OF ENTOMOLOGIST None	
31. NAME OF ENTOMOLOGIST None		32. NAME OF ENTOMOLOGIST None	
33. NAME OF ENTOMOLOGIST None		34. NAME OF ENTOMOLOGIST None	
35. NAME OF ENTOMOLOGIST None		36. NAME OF ENTOMOLOGIST None	
37. NAME OF ENTOMOLOGIST None		38. NAME OF ENTOMOLOGIST None	
39. NAME OF ENTOMOLOGIST None		40. NAME OF ENTOMOLOGIST None	
41. NAME OF ENTOMOLOGIST None		42. NAME OF ENTOMOLOGIST None	
43. NAME OF ENTOMOLOGIST None		44. NAME OF ENTOMOLOGIST None	
45. NAME OF ENTOMOLOGIST None		46. NAME OF ENTOMOLOGIST None	
47. NAME OF ENTOMOLOGIST None		48. NAME OF ENTOMOLOGIST None	
49. NAME OF ENTOMOLOGIST None		50. NAME OF ENTOMOLOGIST None	
51. NAME OF ENTOMOLOGIST None		52. NAME OF ENTOMOLOGIST None	
53. NAME OF ENTOMOLOGIST None		54. NAME OF ENTOMOLOGIST None	
55. NAME OF ENTOMOLOGIST None		56. NAME OF ENTOMOLOGIST None	
57. NAME OF ENTOMOLOGIST None		58. NAME OF ENTOMOLOGIST None	
59. NAME OF ENTOMOLOGIST None		60. NAME OF ENTOMOLOGIST None	
61. NAME OF ENTOMOLOGIST None		62. NAME OF ENTOMOLOGIST None	
63. NAME OF ENTOMOLOGIST None		64. NAME OF ENTOMOLOGIST None	
65. NAME OF ENTOMOLOGIST None		66. NAME OF ENTOMOLOGIST None	
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81. NAME OF ENTOMOLOGIST None		82. NAME OF ENTOMOLOGIST None	
83. NAME OF ENTOMOLOGIST None		84. NAME OF ENTOMOLOGIST None	
85. NAME OF ENTOMOLOGIST None		86. NAME OF ENTOMOLOGIST None	
87. NAME OF ENTOMOLOGIST None		88. NAME OF ENTOMOLOGIST None	
89. NAME OF ENTOMOLOGIST None		90. NAME OF ENTOMOLOGIST None	
91. NAME OF ENTOMOLOGIST None		92. NAME OF ENTOMOLOGIST None	
93. NAME OF ENTOMOLOGIST None		94. NAME OF ENTOMOLOGIST None	
95. NAME OF ENTOMOLOGIST None		96. NAME OF ENTOMOLOGIST None	
97. NAME OF ENTOMOLOGIST None		98. NAME OF ENTOMOLOGIST None	
99. NAME OF ENTOMOLOGIST None		100. NAME OF ENTOMOLOGIST None	

12838

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington				f. STREET ADDRESS 83x-3			
3. NAME OF DECEASED (Type or print) First Ferdinand Middle Eugene Last TRICHE				4. DATE OF DEATH Month November Day 29 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-19-87	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		11. IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVY				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
11. BIRTHPLACE (State or foreign country) Louisiana				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Elphege TRICHE				14. MOTHER'S MAIDEN NAME Corine BLANCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) Yes WW I&II				16. SOCIAL SECURITY NO. INFORMANT			
17. ADDRESS (wife) Mrs. Nellie P. TRICHE				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma, rectum DUE TO (c) adenocarcinoma, rectum			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 30 October 19 59 to 29 November 19 59 that I last saw the deceased alive on 29 November 19 59 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert C. Thomas M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, NMMC DATE SIGNED 30 Nov 59			
PHYSICIAN'S NAME (Type) Robert C. THOMAS, LT MC USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-3-59			
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR (Name and address) S.H. HINES 2901 14th St. NW, Washington, D. C.				24a. RECEIVED BY REGISTRAR DEC 2 1959			
24b. REGISTRAR'S SIGNATURE Charles S. Hines				24c. REGISTRAR'S SIGNATURE Charles S. Hines			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12822

12839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY IN 1b <u>5 Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Marylander.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Joseph</u> Last <u>Wade</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 11-1882</u>
9. AGE (In years last birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>	
11. BIRTHPLACE (State or foreign country) <u>Clopper. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William H. Wade</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Key</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Henry Hickerson. Germantown. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>pneumonia, bilateral</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>59</u> , to <u>Nov. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 18</u> , 19 <u>59</u> , and that death occurred at <u>8:00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Germantown</u> DATE SIGNED <u>Nov 19, '59</u> ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D. PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Rose</u>	22d. LOCATION (City, town, or county) (State) <u>Clopper. Gaithersburg. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett B. Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>

Original

1000 1000

1000 1000

1000 1000

11-11-1916

11-11-1916

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11-11-1916

11-11-1916

11-11-1916

11-11-1916

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12840

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 70 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY 85x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkerburg d. STREET ADDRESS 1801 Broadway Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vere Curtis WALBROUN		4. DATE OF DEATH Month Day Year November 13 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-27
9. AGE (In years last birthday) yrs. 32		10. IF UNDER 1 YEAR Months Days Hours Min. 32	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Wilbur Walbroun		14. MOTHER'S MAIDEN NAME Bertie Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 235 40 9075	
17. INFORMANT Official Government Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissection & Perforation of Acute Aneurysm 445x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis & malignant hypertension DUE TO (c) Chronic Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 September, 1959 , to 13 November, 1959 , that I last saw the deceased alive on 13 November, 1959 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F.H. O'Connell		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.	
PHYSICIAN'S NAME (Type) F.H. O'Connell LCDR MC USN		DATE SIGNED 11-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/59	
22c. NAME OF CEMETERY OR CREMATORY Parkersburg Cemetery		22d. LOCATION (City, town, or county) (State) Parkersburg, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR DATE NOV 19 59	
ADDRESS 1400 Chapin St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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VS A15 (4)
15M 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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19840

CERTIFICATE OF DEATH

212

West Virginia

Montgomery

Historic

To day

Boonville (Rural)

1001 Broadway Ave.

U. S. Naval Hospital, Bethesda Md.

13

November

WILLIAM

C. R. R.

York

32

2-25-27

White

Male

U. S.

West Virginia

U. S. Government

U. S. Navy

Battle Richmond

William Wilson

ORIGINAL Government Record

232-40-2075

WM IT

Yes

13 November

13 November

U. S. Naval Hospital, Bethesda Md. 11-10-20

U. S. Naval Hospital, Bethesda Md.

W. H. O'Connell JOHN M. RICH

U. S. Naval Hospital, Bethesda Md.

U. S. Naval Hospital, Bethesda Md.

12841

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital				d. STREET ADDRESS RFD #1, Box 90			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle S. Last Ward, Sr.				4. DATE OF DEATH Month November Day 12 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Eng. Corp.		11. BIRTHPLACE (State or foreign country) Woodfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ward				14. MOTHER'S MAIDEN NAME Hennie Purdum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-32-4280		17. INFORMANT Mrs Bertha D. Ward, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 days						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/24 , 19 59 , to 11/12 , 19 59 , that I last saw the deceased alive on 11/11 , 19 59 , and that death occurred at 6:55am , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 11/12/59	
PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/59		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mobson				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1385

12842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll Hall</i> <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Hall Sanatorium</i>		d. STREET ADDRESS <i>2900 Conn. Ave. N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Mareta</i> First <i>Mareta</i> Middle <i>McAlster</i> Last <i>Watson</i>		4. DATE OF DEATH Month <i>11</i> Day <i>17</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>?</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles McAlister</i>		14. MOTHER'S MAIDEN NAME <i>Laura Bowman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT M. E. Mrs. Thorne Smith</i> Address <i>1024 14th Ave NW Washington DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of lung</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-17</i> , 19 <i>57</i> , to <i>11-17</i> , 19 <i>59</i> ; that I last saw the deceased alive on <i>11-17</i> , 19 <i>59</i> , and that death occurred at <i>8:15</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Erwin Steinman M.D.</i>		ADDRESS (Street, city or town, state) <i>3500-14th St. N.W.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ERWIN STEINMAN M.D.</i>		<i>Washington 10 DC</i>	
22a. BURIAL, CREMATION, REMAINS (Specify) <i>11/19/59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines Co.</i> ADDRESS <i>2901-14th St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 19 59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Washington

John Doe, age 45

Married

White

Male

Single

Married

Married

Married

Married

Married

Married

Married

Married

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G252 12-1-59 et

12843

CERTIFICATE OF DEATH

12826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>14 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>P</u> Last <u>WAY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28 1875</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PROUGH</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Prough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MR. H. E. WAY</u>	
17. INFORMANT Address <u>SAME AS ABOVE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, posterior</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Thrombosis Posterior Coronary Artery</u> DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma left Breast; Common duct obstruction & cholecystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>57</u> , to <u>Nov 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>59</u> , and that death occurred at <u>3:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.		ADDRESS (Street, city or town, state) <u>10511 Semmit Ave</u> DATE SIGNED <u>11/18/59</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		<u>Keensington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Altamira Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams Funeral Home Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

CERTIFICATE OF DEATH

1968

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

STATE OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF VITAL RECORDS

ALBANY

1968

1968

1968

1968

1968

1968

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

STATE OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF VITAL RECORDS

ALBANY

1968

1968

1968

1968

1968

1968

1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG253 12-3-59 et

12844 CERTIFICATE OF DEATH

12827

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 40 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 89X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 2411 Hemlock Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle Keats Last WHARTON				4. DATE OF DEATH Month November Day 15 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-16 1908	
9. AGE (In years last birthday) 48 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Harold G. Keats				14. MOTHER'S MAIDEN NAME Ella Meenan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. INFORMANT (Husband) Claude A. Wharton Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 November, 1959 to 15 November, 1959 , that I last saw the deceased alive on 15 November, 1959 , and that death occurred at 9:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 11-16-59							
ACTUAL SIGNATURE McAllison, Jr.				M.D. U.S. Naval Hospital, Bethesda Md. 11-16-59			
PHYSICIAN'S NAME (Type) M.E. ALLISON JR LCDR MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington V.a.	
23. FUNERAL DIRECTOR'S SIGNATURE R.T. Murphy ADDRESS 3524 Columbia Pike Arlington Va.				24a. REC'D BY REGISTRAR DATE NOV 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1.2.5) $\text{abs}(1.5e5)$

Reference:

Don't call me a girl!

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9. Film G-252 11/19/59.cac.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilee Nursing Home		d. STREET ADDRESS 1355 Monroe St., N.W.	
3. NAME OF DECEASED (Type or print) LAURA E. WHEELER		4. DATE OF DEATH Nov 2 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1873
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Baker Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Thomas E. Wheeler, Deale, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocardial disease DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Slight chest cold		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 12, 1958 , to Nov 2, 1959 , that I last saw the deceased alive on Oct 25, 1959 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers		ADDRESS (Street, city or town, state) 1919 50th May Rd 11-2-59	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		DATE SIGNED 1919 50th May Rd 11-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/5/59	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zuck		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

TO HOSPITAL / ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as the same appear to me.	
Signed at _____ this _____ day of _____, 19____.	
My commission expires _____ 19____.	
In testimony whereof, I have hereunto set my hand and the seal of the State Department of Health at Baltimore, Maryland, this _____ day of _____, 19____.	
_____ Registrar	
_____ Health Officer	

CERTIFICATE OF DEATH

Reg. Dist. No. 12829

12846

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i> c. LENGTH OF STAY IN 1b <i>3 yrs. 3 mo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY <i>Washington</i> <i>47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Congressional Hospital, Bethesda, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Last <i>White</i> First <i>Daisy</i> Middle <i>Wright</i>		4. DATE OF DEATH Month <i>11</i> Day <i>21</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/6/79</i>
9. AGE (In years last birthday) <i>80</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Denton, Texas, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph E. Wright</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hubbard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Miss J. W. Gibson</i>		Address <i>Belvedere Apts 13 at Massachusetts Washington D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> <i>years</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic heart disease, pyelitis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> to <i>Nov. 20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov. 20</i> , 19 <i>59</i> , and that death occurred at <i>2:40</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Bowditch Hunter, Jr.</i>		ADDRESS (Street, city or town, state) <i>809 Veins Mill Rd</i>	
PHYSICIAN'S NAME (Type) <i>G. Bowditch Hunter, Jr. M.D. Rockville, Md.</i>		DATE SIGNED <i>11/21/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/23/59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Pauls</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kline</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 24 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

12847

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Co. Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5651 Silver Spring, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>1406 - Burnt Mills Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jean</i> Middle <i>R.</i> Last <i>Wikes</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>9</i> Year <i>1959</i>		5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/14/08</i>		9. AGE (In years last birthday) <i>51</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i> Hours <i>1</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>		13. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. FATHER'S NAME <i>Robert F. Ross Jr.</i>		16. MOTHER'S MAIDEN NAME <i>Mathilda Chamberlain</i>		17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		18. SOCIAL SECURITY NO. <i>577-46-5839</i>	
19. INFORMANT <i>Wade M. Wikes</i>		20. ADDRESS <i>1406 - Burnt Mills Ave. Silver Spring, Md.</i>		21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY METASTASES</i> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>CARCINOMA OF BREAST</i> DUE TO (c) <i>5 YEARS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 WEEKS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>NONE</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>AUG 15, 1959</i> , to <i>NOV. 9, 1959</i> , that I last saw the deceased alive on <i>NOV. 9, 1959</i> , and that death occurred at <i>5 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John H. Toohy</i>		M.D. <i>7720 WASCONSIN AVE</i>		DATE SIGNED <i>11/9/59</i>		ADDRESS (Street, city or town, state) <i>BETHESDA 14, MD.</i>	
PHYSICIAN'S NAME (Type) <i>JOHN H. TOOHY, M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/12/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	
22d. LOCATION (City, town, or county) (State) <i>Silver Spring Md</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Z...</i>		ADDRESS <i>Silver Spring Md.</i>		24. REGISTRAR'S SIGNATURE <i>Warner E. Humphrey Inc.</i>	
DATE <i>NOV 13 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Warner E. Humphrey Inc.</i>		DATE <i>NOV 13 '59</i>		24c. REGISTRAR'S SIGNATURE <i>Warner E. Humphrey Inc.</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1964



MADE IN U.S.A.
MADE IN U.S.A.
MADE IN U.S.A.



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

12848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7402 Fairfax Rd, Beth, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ronald W. Wilson</u>				4. DATE OF DEATH <u>11 28 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4 1891</u>	
9. AGE (In years last birthday) <u>68</u>		10. IF UNDER 1 YEAR <u>5</u> Months <u>24</u> Days		11. IF UNDER 24 HRS. <u>5</u> Hours <u>24</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Engr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Interior</u>			
11. BIRTHPLACE (State or foreign country) <u>Quincy, Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel Munro Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Ella C. Handy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1917 to 1919</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Dorothy I. Wilson-Wife - Item #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/27</u> , 19 <u>52</u> , to <u>11/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. T. Joyner</u>				ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>William T. Joyner</u>				DATE SIGNED <u>DEC 2 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1943

CHIEF CLERK

1

1

WILLIAM T. JOYCE
10/21/43
10/21/43
10/21/43

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12833

Reg. Dist. No.

12849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10009 Reddick Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>10009 Reddick Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nellie Esther Wiseman</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1884</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>12-20-88</u> 9. AGE (In years, last birthday) <u>71</u> yrs.			4. DATE OF DEATH <u>Nov 16 1959</u> Month Day Year IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Me.</u> 12. CITIZEN OF WHAT COUNTRY? <u>21-54</u>		13. FATHER'S NAME <u>John H. Wiseman</u> 14. MOTHER'S MAIDEN NAME <u>Clark</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Thelma Lewis - daughter -</u> Address <u>Stn 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-16-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIP & BURIAL NOV. 16, 1959</u>		22b. DATE THEREOF <u>NOV. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RAVENNA CEMETERY (BUFFALO CO) RAVENNA, NEBRASKA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc., Silver Spring, Md.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>NOV 18 59</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>				DATE SIGNED			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.

12850

CERTIFICATE OF DEATH

12834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Hall Sanitarium</u> <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b -----			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>				d. STREET ADDRESS <u>3136 Key Blv'd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>WITHAM</u> Middle <u>W</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-19-72</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Gov't.</u>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Edward Witham</u>				14. MOTHER'S MAIDEN NAME <u>Anna T. Tomlinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Mrs. Cassidy (executive apointee)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> <u>420.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1957</u> to <u>11-28, 1959</u> that I last saw the deceased alive on <u>11-28-59</u> 19, and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Heusen London</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 Norway Dr.,</u> <u>Cherry Chase, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Cherry Chase, Md.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 12-2-1959</u>		22b. DATE THEREOF <u>12-2-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons, Wash. 6, D.C.</u>				ADDRESS <u>Wash. 6, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

12320

DEPARTMENT OF HEALTH

1

CERTIFICATE OF DEATH

Reg. Dist. No.

12851

12855

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days, 14 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillandale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Crest Haven Drive			
3. NAME OF DECEASED (Type or print) First Sarah Middle Roberta Last Withers				4. DATE OF DEATH Month Nov. Day 12 Year 1959			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1917		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	IF UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Un k n o w n				14. MOTHER'S MARDEN NAME Marian Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Berry Withers, Crest Haven Drive Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction Right auricle DUE TO (c) Chronic renal insufficiency DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days 1 month 1 year							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-9 , 19 59 , to 11-12 , 19 59 , that I last saw the deceased alive on 11-11 , 19 59 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah T. Kinside				ADDRESS (Street, city or town, state) 929 Pershing Drive 11-12-59			
PHYSICIAN'S NAME (Type) L. S. Spring, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kins	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951



12852 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

12836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1811 North Royer Street							
3. NAME OF DECEASED (Type or print) First Kurt Middle Amandus Last Wittges				4. DATE OF DEATH Month November Day 7 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1900	
9. AGE (In years lost birthday) 59		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Manager				10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Max Wittges				14. MOTHER'S MAIDEN NAME Hedwig Getzschmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —			
17. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic malignant carcinoid DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 21, 19 59 to November 7, 19 59 that I last saw the deceased alive on November 7, 19 59 , and that death occurred at 8:54 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-7-59 ACTUAL SIGNATURE Laurence E. Earley M.D. The Clinical Center PHYSICIAN'S NAME (Type) Laurence E. Earley, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 11-12-1959							
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN Cem.							
22d. LOCATION (City, town, or county) (State) FL Paso Co. COLO.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey							
ADDRESS Bethesda, Md.							
24a. REC'D BY REGISTRAR DATE NOV 12 '59							
24b. REGISTRAR'S SIGNATURE Arthur J. Hays							

MEDICAL CERTIFICATION

2

1

050

STATEMENT OF DEATH

1952

Colorado

Montgomery

17 days

Atlanta

The Clinical Center, Bethesda, Md., 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Atlanta

Atlanta

Atlanta

January 1, 1900

White

Male

Nebraska

Nebraska

General Hospital

Medical Department

Medical Department

The Medical Department

The Medical Department

Cardiovascular collapse

Cardiovascular collapse

October 21, 1952

November 1, 1952

The Clinical Center

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November 1, 1952

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12837

Reg. Dist. No.

12694

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14. + 25 min</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>				d. STREET ADDRESS <u>8401 Flower Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Vincent</u> Last <u>Woltz</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-07</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Raymond Woltz</u>				14. MOTHER'S MAIDEN NAME <u>Mary F. Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>141-03-0183</u>		17. INFORMANT <u>Mrs. Barbara Nestler</u> Address <u>7905 Lockn Ave Tr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> (c) <u>Coronary Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-1-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 4 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J Arthur Walters</u>				ADDRESS <u>254 Canal St. NW</u>		24a. REG'D BY REGISTRAR <u>NOV 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. K...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12695 Item 9 Film G252 11-27-59 et

CERTIFICATE OF DEATH

12838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR 2mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				d. STREET ADDRESS <u>517 University Blvd W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Nancy Young</u>				4. DATE OF DEATH Month Day Year <u>11 20 1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-08</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Thomas Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Pl's Hosp. Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN stem compression</u> 193.0 DUE TO <u>Increased intracranial pressure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral glioma</u> APPROX <u>18 mos</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>58</u> to <u>Nov</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 19, 1959</u> , and that death occurred at <u>4:40 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Lord</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2025 Eye St NW Wash 11/20/59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN L. LORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>11/22/59</u>		<u>West Glade Run Presbyterian Church Cemetery</u>		<u>WORTHINGTON, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisk</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12885

RECEIVED

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